

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17131 CERTIFICATE OF DEATH 17122											
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middletown				c. LENGTH OF STAY IN 1b 15 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middletown 10-1				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Main Street						d. STREET ADDRESS Main Street					
3. NAME OF DECEASED (Type or print) J. GUY AHALT						4. DATE OF DEATH Month December Day 12, Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1901		9. AGE (In years last birthday) 64 Yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural Letter Carrier				10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Albert M. Ahalt						14. MOTHER'S MAIDEN NAME Norma Beachley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-46-1230		17. INFORMANT Address Mrs. Helen Ahalt, Middletown, Maryland.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO (b) Advanced generalized atherosclerosis 2 yrs DUE TO (c) Hypertension & Coronary Artery Disease 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peritonitis & Sepsis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1962 to 12/12, 1966, that (I) (we) last saw the deceased alive on about 8/15/1966, and that death occurred at 11:45 M, from the causes and on the date stated above.											
22a. SIGNATURE C. J. Lawrence, M.D.						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) C. J. LAWRENCE						22d. ADDRESS Jefferson, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/66		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town or county) (State) Middletown, Fred. Co. Md.					
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Maryland.						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE J. Charles Judge			
DATE DEC 16 1966											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 10.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital						d. STREET ADDRESS 122 Catoclin Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosella McLeod Arnold						4. DATE OF DEATH Month Day Year December 12- 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16-1901		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Admissions Director				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) Norfolk- Va.				12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Norman McLeod						14. MOTHER'S MAIDEN NAME Annie Hoge					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 201-16-1990D		17. INFORMANT Address Mrs. James C. Reeves-3112 Bryan Road- Burtonsville-Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis 170X DUE TO Carcinoma of breast (rad. mastectomy) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO										INTERVAL BETWEEN ONSET AND DEATH 1963 1954	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1954, 19 to 12 Dec 1966, that (I) (we) last saw the deceased alive on 11 Dec 1966, and that death occurred at 11:20A from the causes and on the date stated above.											
22a. SIGNATURE Charles H. Conley, Jr. M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 12-1966			
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.						22d. ADDRESS Professional Bldg.- Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-15-1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Washington-D.C. 3201 Bladensburg Road-					
24 FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son						ADDRESS Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE DEC 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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(1-7-74) 13153

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FOR STATE  
HEALTH DEPT.

17133

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17124

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>D O A</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>9501 Franklin avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>M.</b> Last <b>Barr</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 13, 1932</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Martin I Barr Sr</b>		14. MOTHER'S MAIDEN NAME <b>Thelma B Henderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes Korean</b>		16. SOCIAL SECURITY NO. <b>214 36 4506</b>	
17. INFORMANT <b>Elizabeth Barr</b>		Address <b>Seabrook, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Avulsion of Skull &amp; Brain; Crush</b> DUE TO <b>Fractures all extremities; Ruptured</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Liver &amp; Spleen &amp; Heart</b> (c) <b>Liver &amp; Spleen &amp; Heart</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aircraft crash</b>	
20c. TIME OF INJURY Hour <b>3:10</b> p.m. Month, Day, Year <b>12-10-1966</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mountain Top</b>	20f. (City or town) (County) (State) <b>Frederick - Frederick Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 15, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17134

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17125

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highway- Jefferson</b>		c. LENGTH OF STAY IN 1b <b>Jefferson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1011</b>	
3. NAME OF DECEASED (Type or print) First <b>Gilbert</b> Middle <b>A.</b> Last <b>Berry-Jr.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13-1934</b>
9. AGE (In years last birthday) <b>32 yrs</b>		10. IF UNDER 1 YEAR Months <b>32</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Berryville- Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gilbert A. Berry-Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Marie Butler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1963</b>		16. SOCIAL SECURITY NO. <b>215-34-2760</b>	
17. INFORMANT <b>Mrs. Louise Wright Berry-Jefferson, Md.</b>		Address <b>21755</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Asphyxia - Blood</b> DUE TO (b) <b>Fractured Maxilla</b> DUE TO (c) <b>Fractured Maxilla</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Two car collision</b>	
20c. TIME OF INJURY Month, Day, Year <b>5</b> Hour <b>am</b> <b>12-16</b> <b>1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Jefferson - Frederick - Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b> EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>		22. DATE SIGNED <b>12-16-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 20-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Meth. Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Jefferson, Md. 21755</b>	
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>		25. REC'D BY REGISTRAR <b>Edwood T. Frederick, Md. 21701</b>	
25a. DATE <b>DEC 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	

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VR A15 (4)  
20M 1/65

<div>1</div> <div> <div>17135</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> </div> <div> <div>CERTIFICATE OF DEATH</div> <div>17126</div> </div>									
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <div>MARYLAND</div>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural 21755</b>			c. LENGTH OF STAY IN 1b <b>90 Yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Jefferson-Rural 21755</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Near Jefferson</b>					d. STREET ADDRESS <b>Near Jefferson</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div>First Middle Last</div> <b>JOHN STEPHEN BOWLUS</b>					4. DATE OF DEATH <div>Month Day Year</div> <b>December 18, 1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6 April 1873</b>		9. AGE (In years last birthday) <b>93</b> yrs. <div>             IF UNDER 1 YEAR              Months Days Hours Min.           </div>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer &amp; Minister of the Gospel</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>of the Gospel</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Near Broad Run, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Franklin L. Bowlus</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Beachley</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219 05 2149</b>		17. INFORMANT <b>Miss Sarah E. Bowlus</b>					Address <b>(Same as item #1)</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition and Cerebratory plaque</b> <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Advanced Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>2 mo</b> <b>3 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10:00</b> to <b>12/18, 1966</b> , that (I) (we) last saw the deceased alive on <b>12/17, 1966</b> , and that death occurred at <b>12:15 P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>A. Talbott Brice, M. D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>19 Dec 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Talbott Brice, M. D.</b>						22d. ADDRESS <b>Jefferson, Maryland 21755</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant View Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Near Burkittsville, Md.</b>		
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md. 21701</b>						25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

2551

2. 1997年12月15日，在《人民日报》发表署名文章《论中国加入世界贸易组织》，指出中国加入世界贸易组织是中国的机遇，也是世界的机遇。

FOR STATE  
HEALTH DEPT.

17136

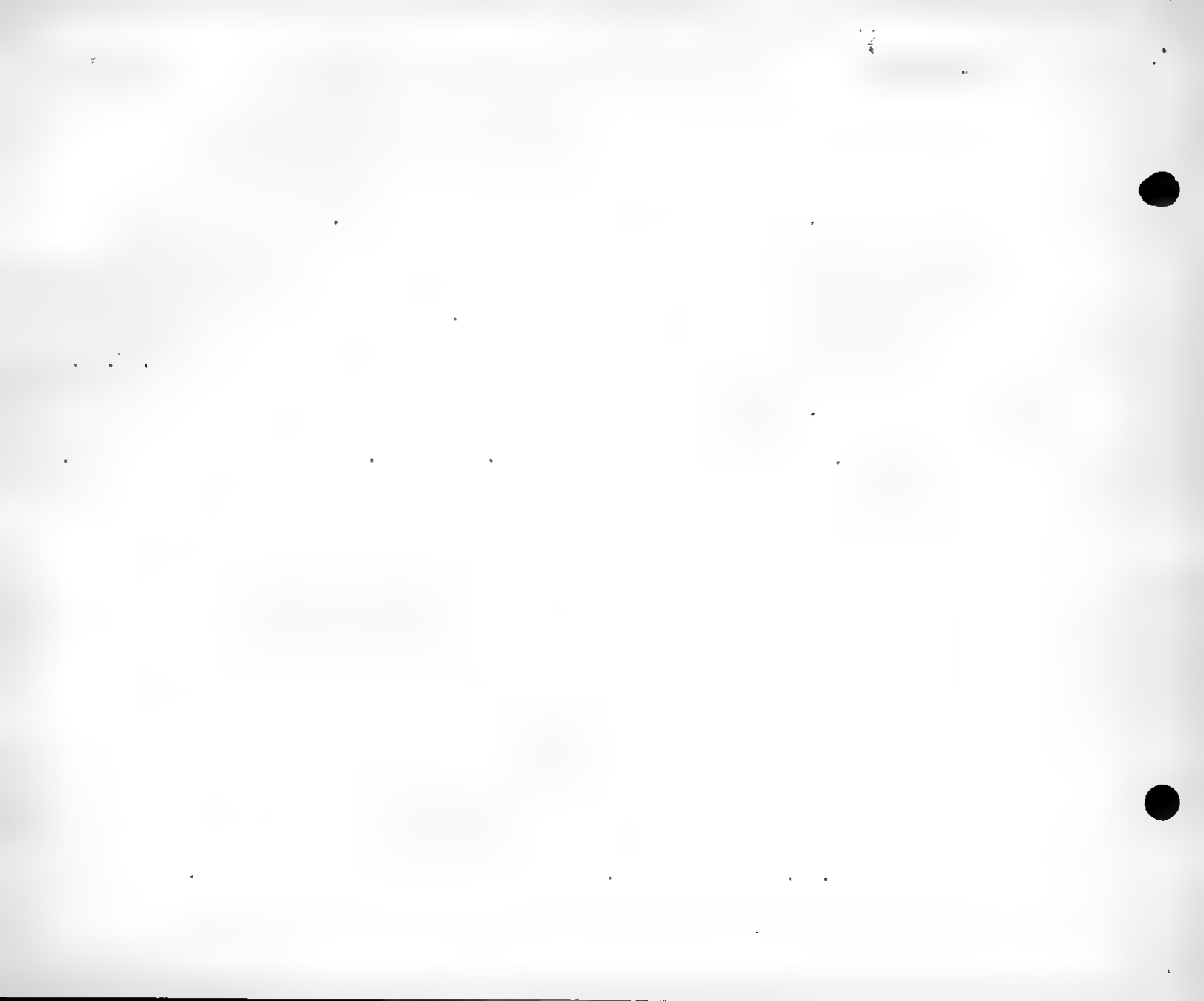
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17127

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10 East 14th. Street</b>		d. STREET ADDRESS <b>10 East 14th. Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGIE</b> Middle <b>RENN</b> Last <b>CASWELL</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>4</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. CO. OR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1900</b>	9. AGE (n years last birthday) yrs <b>66</b>	F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Adamstown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William H. Renn</b>		14. MOTHER'S MAIDEN NAME <b>Edith Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W. W. # 1</b>		16. SOCIAL SECURITY NO <b>579 22 2774</b>		17. INFORMANT Address <b>Mrs. Norman F. Filliaux, Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B. O. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county) <b>Dec. 4, 1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	
23d. LOCATION (City or Town) <b>Frederick, Maryland</b>		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR <b>Donald M. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17137

CERTIFICATE OF DEATH

17128

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Emmitsburg.</b> c. LENGTH OF STAY IN 1b <b>75 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Emmitsburg</b> d. STREET ADDRESS <b>IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Henry Cool</b>		4. DATE OF DEATH Month Day Year <b>December 19, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1883</b>
9. AGE (In years last birthday) <b>83 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>Adams Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel D. Cool</b>		14. MOTHER'S MAIDEN NAME <b>Ida J. Sanders</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-10-5787</b>	
17. INFORMANT <b>Mrs. Susan Cool, Fairfield, Pa.</b>		Address <b>R.D. # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Oct</b> , 19 <b>59</b> , to <b>12/16/66</b> , that (we) last saw the deceased alive on <b>12/14/66</b> , and that death occurred at <b>3 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>George F. Moringstar</b> M.D.		22b. DATE SIGNED <b>12/20/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>George F. Moringstar</b>		22d. ADDRESS <b>Emmitsburg, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 23, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Emmitsburg, Frederick Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Clarence E. Wilson</b> ADDRESS <b>Emmitsburg, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

VR A15 (4)  
20 M 1/66





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

47138

CERTIFICATE OF DEATH

Items 23c, 23d fill in 12/14/66 mh

17129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 5 Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>		d. STREET ADDRESS <b>Route # 5</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>RALPH EDWARD CULLER</b>		First		Middle		Last		4. DATE OF DEATH <b>December 6 1966</b>		Month		Day		Year					
5. SEX <b>male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 17, 1897</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John J. Culler</b>		14. MOTHER'S MAIDEN NAME <b>Annie Thomas</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 30 9995</b>		17. INFORMANT <b>Mrs. Olive Culler (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Stenosis, mitral Stenosis and regurgitation - Known since 1962</b> Conditions, if any, which gave rise to immediate cause (b) <b>Rheumatic heart disease.</b> (a), stating the underlying cause last (c) <b>?</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>7:00 P.M. 1962</b> to <b>6:00 P.M. 1962</b> , that (I) (we) last saw the deceased alive on <b>7:00 P.M. 1962</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Charles H. Conley, Jr.</b> M.D.								ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>Dec 6, 1966</b>							
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr. M. D.</b>								22d. ADDRESS <b>228 N. Market Street, Frederick, Md.</b>											
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Dec. 8, 1966</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Donald M. Hatcher</b> ADDRESS <b>D. K. Hatcher &amp; Son, Frederick, Maryland</b>								25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>								25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>			

MEDICAL CERTIFICATION



17139

CERTIFICATE OF DEATH

17139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN b. years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>24 West 12th Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>24 West 12th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH WILLIAM DARNER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1876</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Robert Darner</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Crampton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-48-8743</b>	
17. INFORMANT <b>Miss Alice Darner</b>		Address <b>24 W. 12th St. Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Similarity with arteriosclerotic heart disease</b> 191.9 DUE TO <b>Stomach cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 2-3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>12-29-1966</b> , that (I) (we) last saw the deceased alive on <b>12-1-1966</b> , and that death occurred at <b>12-29-1966</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Rex R. Martin</b>		22b. DATE SIGNED <b>12-29-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin</b>		22d. ADDRESS <b>220 North Market Street Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-31-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Jefferson, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Bailey &amp; Son</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
ADDRESS <b>Frederick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17140					17131				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Frederick</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>123 N. Virginia Ave.</b>					d. STREET ADDRESS <b>same</b>				
3. NAME OF DECEASED (Type or print) <b>SARAH First MARGARET Middle DEVINE Last</b>					4. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1966</b>				
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/5/1896</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Loudoun Co. Virginia</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Benjamin Mock</b>					14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Taulton</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-18-8631</b>		17. INFORMANT <b>Edith Alger</b>			Address <b>Brunswick Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary G. Atherosclerosis</b> 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Extensive heart disease</b> DUE TO (c) <b>Chronic bronchial asthma</b>								INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11-1-1966</b> , to <b>12-9-1966</b> , that (I) (we) last saw the deceased alive on <b>12-9-1966</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-10-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>C.E. Pruitt M.D.</b>				22d. ADDRESS <b>Brunswick Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Heights Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Brunswick Md.</b>			
24. FUNERAL DIRECTOR <b>Leete Funeral Home</b>				ADDRESS <b>Brunswick Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17141

17132

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b> c. LENGTH OF STAY IN 1b <b>5 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Vindobona Convalescent &amp; Rest Home</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>42 East Patrick Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>NEWMAN</b> Last <b>ENGLAND</b> 4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1966</b>				5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>30 Jan 1877</b> 9. AGE (In years last birthday) <b>89</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Woodsboro, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>				13. FATHER'S NAME <b>Jacob M. Newman</b> 14. MOTHER'S MAIDEN NAME <b>Katherine Shaw</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>212-38-9104</b> 17. INFORMANT <b>303 Upper College Terrace, Parsons Newman, Frederick, Md. 21701</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO (b) <b>Cerebral Arteriosclerosis (Sen cty)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hematuria - Cause unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1966</b> to <b>Dec. 31, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 31, 1966</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.				22a. SIGNATURE <b>A. A. Pearre, Sr.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>12/31/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. A. Pearre, Sr.</b> 22d. ADDRESS <b>4 E. Church St., Frederick, Md. 21701</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1/3/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Frederick, Md. 21701</b>			
24. FUNERAL DIRECTOR <b>Frank B. Smith</b> ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Md. 21701</b> 25a. REC'D BY REGISTRAR <b>JAN 3 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17142 CERTIFICATE OF DEATH 17133									
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middletown					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Nursing Home				e. STREET ADDRESS Prospect St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Glenn Last Gladhill			4. DATE OF DEATH Month 12 Day 2 Year 19 66						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/2/66 1900		9. AGE (In years last birthday) 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) furniture salesman			10b. KIND OF BUSINESS OR INDUSTRY retail			11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Calvin T. K. Gladhill					14. MOTHER'S MAIDEN NAME Lola Mae Wiles				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 213-01-5472		17. INFORMANT Kenneth A. Gladhill, Middletown, Md.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 434.4 IMMEDIATE CAUSE (a) Chronic Congestive Failure DUE TO (b) Ch. Cor Pulmonale DUE TO (c) Ch. Pulmonary Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GOUT								INTERVAL BETWEEN ONSET AND DEATH 1 year 6 yrs. 10+	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 1957 to 12/2 1966, that (I) (we) last saw the deceased alive on 12/1 1966, and that death occurred at 7 AM, from the causes and on the date stated above.									
22a. SIGNATURE Charles H. Conkey, Jr.					22b. DATE SIGNED 2 DEC 1966		22c. PHYSICIAN'S NAME (Type) CHARLES H. CONKEY, JR.		
22d. ADDRESS FREDERICK, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 12/4/66		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town or county) (State) Middletown, Md.		
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.					25a. REC'D BY REGISTRAR DEC 5 1966 DATE		25b. REGISTRAR'S SIGNATURE		



17143

## CERTIFICATE OF DEATH

17134

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lantz</b>		c. LENGTH OF STAY in lb <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Own Home</b>		d. STREET ADDRESS <b>Lantz</b>	
3. NAME OF DECEASED (Type or print) <b>Frederick Lee Green</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1915</b>
9. AGE (In years birthday) <b>51</b> yrs		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Rex Green</b>		14. MOTHER'S MAIDEN NAME <b>Violet Wolf</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>216-03-7588</b>	
17. INFORMANT <b>Helen L. Green</b>		Address <b>Lantz, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>5-10 minutes</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-27</b> , 1954, to <b>23 Dec</b> , 1966, that (I) (we) last saw the deceased alive on <b>Oct 24</b> , 1966, and that death occurred at <b>2:00 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Harry H. Youngs</b>		22b. DATE SIGNED <b>12-23-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry H. Youngs</b>		22d. ADDRESS <b>Blue Ridge Summit, Pa.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-26-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Bethel Meth. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Foxville Fred. Co. Md.</b>
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>		25a. REC'D BY REGISTRAR <b>W.C. 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





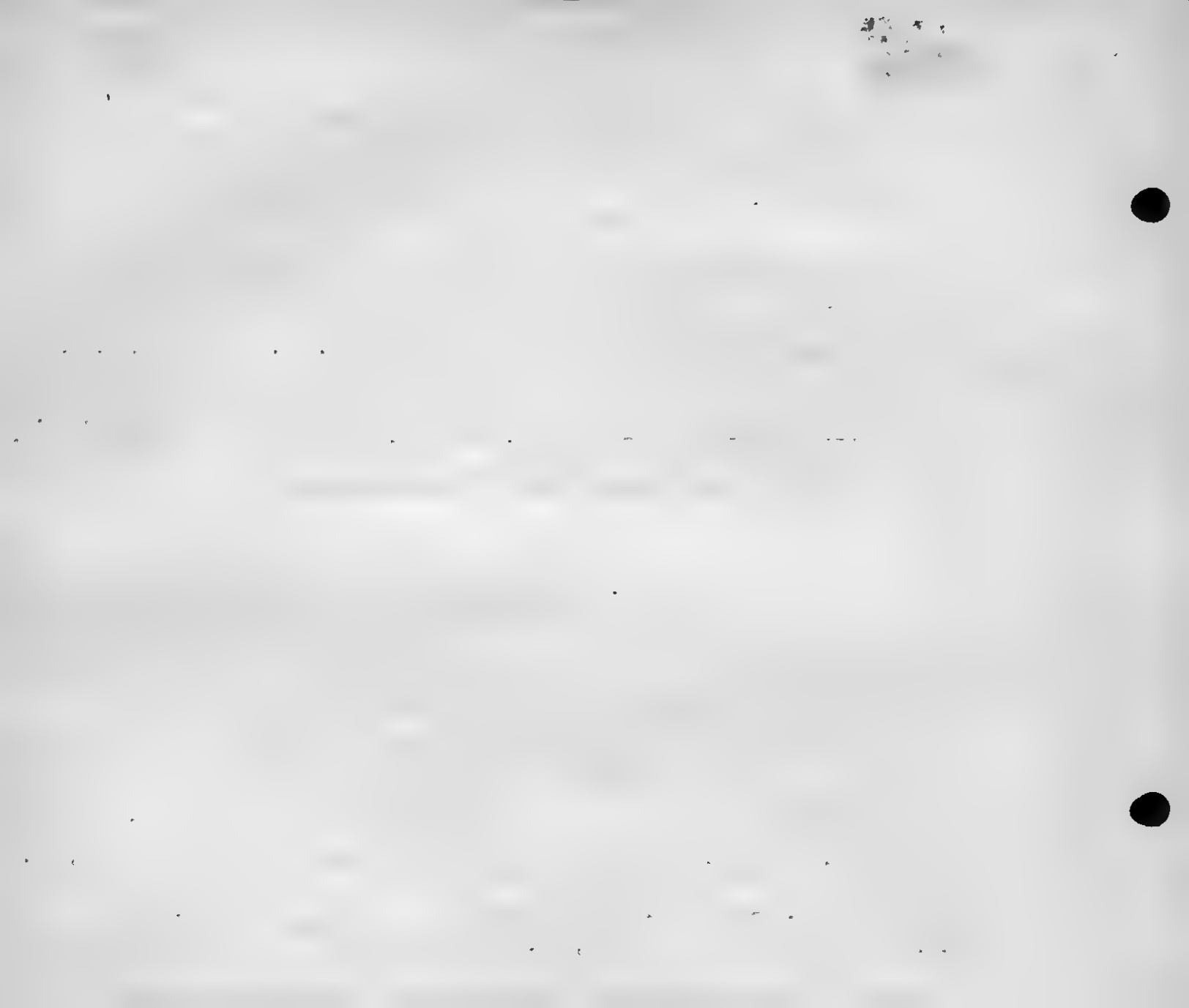
CERTIFICATE OF DEATH

17144

17135

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>24 Winchester Street</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>24 Winchester Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elmer Lester Hargett</b>				4. DATE OF DEATH Month <b>December</b> Day <b>6-</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 6- 1885</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Contractor</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Simeon Hargett</b>				14. MOTHER'S MAIDEN NAME <b>Mahalia Griffith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-10-3568A</b>		17. INFORMANT Address <b>Frederick, Md.</b> <b>Mrs. Minnie E. Smith Hargett-24 Winchester St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> <b>334X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>January, 1965</b> to <b>Dec. 4, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec. 4, 1966</b> and that death occurred at <b>12:05A</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. J. Riddick</b>				22b. DATE SIGNED <b>Dec. 6-1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Willis J. Riddick</b>	
22d. ADDRESS <b>Frederick Medical Center-Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 8-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) _____ (State) _____ <b>Frederick, Md. 21701</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M.R. Etchison &amp; Son</b>				25. REC'D BY REGISTRAR <b>DEC 9 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

17145

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17136

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY in 1b Hours Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear 602 Trail Avenue		d. STREET ADDRESS Apt. #5, John Hanson	
3 NAME OF DECEASED (Type or print) First Middle Last Sandra Lee Harley		4 DATE OF DEATH Month Day Year December 15- 19 66	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 13, 1952
9 AGE (In years past birthday) 14 yrs		10 UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY High School	
11 BIRTHPLACE (State or foreign country) Frederick, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Paul G. Harley		14 MOTHER'S MAIDEN NAME Alice Martin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT Mr. Paul G. Harley (Same as item # 2)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carbon monoxide poisoning 891.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carbon monoxide poisoning - in close garage			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Garage was filled with Carbon Monoxide fumes	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 15 19 66 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Garage	20f (City or town) (County) (State) Frederick, Frederick Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 18, 1966	23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens,	23d LOCATION (City or Town) (County) (State) Mr. Hansonville, Maryland
24. FUNERAL DIRECTOR Donald M. Fitchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DEC 19 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
17146		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				17137				
1 PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rt 26 Liberty</b>			c. LENGTH OF STAY IN lb <b>minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt Airy</b>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt 26 Nr Libertytown</b>					d. STREET ADDRESS <b>Rt 4</b>					
3 NAME OF DECEASED (Type or print) <b>Harold Martin Harris</b>					4 DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1966</b>					
5 SEX <b>Male</b>		6 COLOR OR RACE <b>Negro</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>3-16-1943</b>		9 AGE (n years lost birthday) yrs <b>23</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Construction labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Md</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Carl C. Harris</b>					14. MOTHER'S MAIDEN NAME <b>Anna L. Ambush</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>***** 213-42-1667</b>		17. INFORMANT Address <b>Mrs Anna L Harris Rt.4 Mt Airy, Md</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 8:25.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Massive Hemorrhage</b> DUE TO (c) <b>Ruptured Liver &amp; Spleen</b>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident</b>						
20c. TIME OF INJURY Month, Day, Year <b>7:40 p.m. 12-4-1966</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Liberty - Frederick - Md.</b>		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/8/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Church</b>			23d. LOCATION (City or Town) (County) (State) <b>Frederick County Md</b>			
24. FUNERAL DIRECTOR <b>C.E. Hicks, III</b>					ADDRESS <b>Frederick, Md</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





FOR STATE  
HEALTH DEPT.

17147

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17138

1 PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Mt. Airy</b>		c. LENGTH OF STAY in 1b <b>22 Years</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Rural-Mt. Airy</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D. 4</b>				d. STREET ADDRESS <b>R.D. 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>D.</b> Last <b>HARRIS</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>4</b> Year <b>1966</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Jan. 24, 1909</b>	
9 AGE (In years last birthday) yrs <b>57</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>	
13. FATHER'S NAME <b>John T. Harris</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 2</b>				16 SOCIAL SECURITY NO <b>218-05-4164</b>		17 INFORMANT <b>George Miller</b> Address <b>R.D. Mt. Airy, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>3220</b> DUE TO <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Acute alcoholism</b> (c) <b>Exposure to freezing temperature</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS A AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D.				22. DATE SIGNED <b>12-5-66</b>			
EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/8/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Leisters Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Carroll Co., Md.</b>	
24 FUNERAL DIRECTOR <b>C. M. Waltz</b> Address <b>Box 241 Sykesville, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 9 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. J. Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17148											
Item 14 Film C-384-17467-17468											
17139											
1. PLACE OF DEATH a. COUNTY Frederick						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital						d. STREET ADDRESS 536 West Potomac Street					
3. NAME OF DECEASED (Type or print) Wilbur						4. DATE OF DEATH DEC 21 1966					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 18 1895		9. AGE (in years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinist				10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		11. BIRTHPLACE (County & State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Harrison						14. MOTHER'S MAIDEN NAME Louisa Mills					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 705-10-2735		17. INFORMANT Virgie B. Harrison Brunswick Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left lower lobe + embolus - pneumonia (b) Pulmonary embolus + pneumonia (c) Decubitus ulcer + pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 16 DEC 1966, to 21 DEC 1966, that (I) (we) last saw the deceased alive on 21 DEC 1966, and that death occurred at 4 PM, from the causes and on the date stated above.											
22a. SIGNATURE Charles H. Conley, Jr.						22b. DATE SIGNED 21 DEC 1966					
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr. M.D.						22d. ADDRESS Fredrick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/23/66		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery			23d. LOCATION (City, town or county) (State) Middletown Maryland			
24. FUNERAL DIRECTOR Teete Funeral Home						25a. REC'D BY REGISTRAR DEC 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			







17150

## CERTIFICATE OF DEATH

17141

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>28 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial</b>		d. STREET ADDRESS <b>127 S. Bentz Street</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Edward Henson</b>		4. DATE OF DEATH <b>December 28 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 25, 1906</b>
9. AGE (in years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR: Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Principal</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eli Henson</b>		14. MOTHER'S MAIDEN NAME <b>Lula Hicks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Gwendolyn B. Henson</b>		Address <b>Frederick, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured Spleen Artery Junction</b> DUE TO (b) <b>Chronic Spleen's Cardiovascular Disease</b> DUE TO (c) <b>Chronic Spleen's Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/20/66</b> to <b>12/28/66</b> that (I) (we) last saw the deceased alive on <b>12/28/66</b> 19 <b>66</b> , and that death occurred at <b>12/28/66</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert J. Thomas</b>		22b. DATE SIGNED <b>12/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Thomas</b>		22d. ADDRESS <b>812 Toll House Ave, Frederick, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-31-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Balto Md</b>	
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111 Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles G. Gedge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles G. Gedge</b>		DATE <b>JAN 3 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

17151

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17142

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Mt. Airy</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Mt. Airy</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D. # 4</b>				d. STREET ADDRESS <b>R.F.D. # 4</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bernard Washington Howell</b>				4. DATE OF DEATH Month Day Year <b>Dec. 13 19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1907</b>	9. AGE (In years last birthday) yrs <b>59</b>	F UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Charlestown, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph William Howell</b>				14. MOTHER'S MAIDEN NAME <b>Dora Louise Hoff</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-18-8906</b>		17. INFORMANT Address <b>Mrs Thelma C. Howell, Item 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. P. Thomas</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. P. Thomas M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, c.ty, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



17152

CERTIFICATE OF DEATH

17143

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural- Frederick</b> c. LENGTH OF STAY IN 1b <b>Month</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montevue Infirmary</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>1 West Ninth Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <b>Ethel May Jackson</b>		4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1966</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 8, 1876</b>		9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>1</b>		11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>George Barber</b>				14. MOTHER'S MAIDEN NAME <b>Gennie Carnahan</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>1538</b>					
17. INFORMANT <b>Mrs. Hilda Benton, 6616 Alleghany Ave.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic adenocarcinoma of colon</b> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Adenocarcinoma of colon</b> (c), stating the underlying cause last. DUE TO (c) <b>Adenocarcinoma of colon</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year 6 years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 9, 1966</b> to <b>Dec 31, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 31, 1966</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.																	
22a. SIGNATURE <b>LeRoy T. Davis</b>				22b. DATE SIGNED <b>12/31/66</b>				22c. PHYSICIAN'S NAME (Type) <b>LeRoy T. Davis, M.D.</b>				22d. ADDRESS <b>228 N. Market Street, Frederick, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 4, 1967</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>M.R. Etchison &amp; Son</b>				24b. ADDRESS <b>Frederick, Md. 21701</b>				25a. REC'D BY REGISTRAR <b>JAN 5 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**17153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17144**

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>1 week</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Fredrick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lewistown</b> d. STREET ADDRESS <b>101</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>O.</b> Last <b>Kanode</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>25,</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1877</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>10</b> Hours <b>15</b> Mn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eli Rice</b>		14. MOTHER'S MAIDEN NAME <b>Rosanna Rodgers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-52-2193</b>	
17. INFORMANT <b>Arnold Kanode</b>		Address <b>Lewistown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> <b>Coronary arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <b>Fracture right hip 12/19/66</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James B. Thomas</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>12/25/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-28-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lewistown Fred Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>		Address <b>Thurmont, Md.</b>	
25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James B. Thomas</b>	



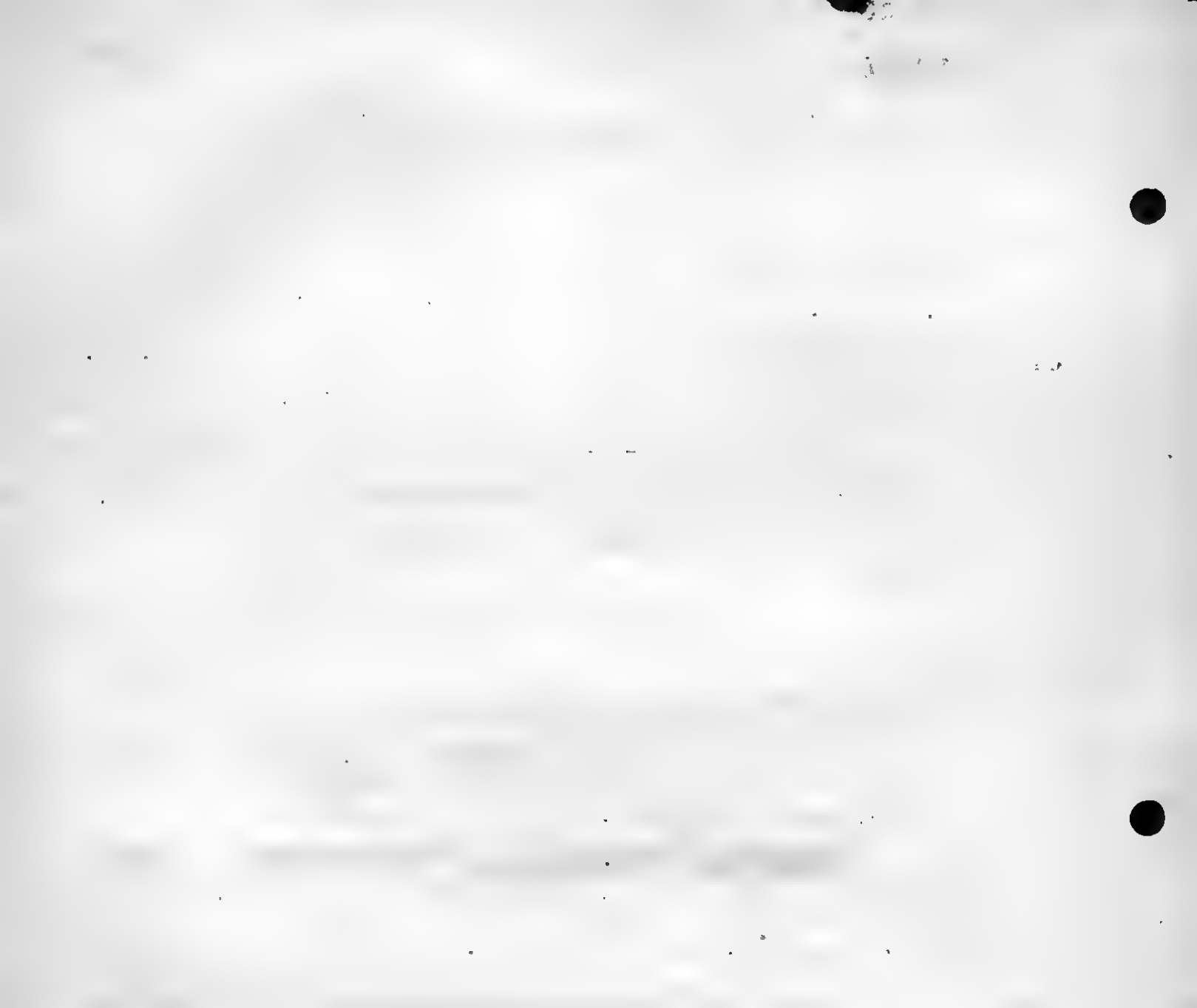
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17154 CERTIFICATE OF DEATH 17145

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue Infirmary		d. STREET ADDRESS 311 Brunswick Street	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle REBECCA Last KIDD		4. DATE OF DEATH Month I2 Day 3 Year 1966	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Charles Fout		14. MOTHER'S MAIDEN NAME Margaret Mahoney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-50-8683	
17. INFORMANT Address		Gale Whitcomb Rockville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis (b) Atherosclerotic C.V.D. (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 minutes 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1966, to Dec 3, 1966, that (I) (we) last saw the deceased alive on Dec 3, 1966, and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Bernard O. Thomas M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) BERNARD O. THOMAS, M.D. 22d. ADDRESS 311 BRUNSWICK ST. MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12/6/66	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick Maryland
24. FUNERAL DIRECTOR Fete Funeral Home		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS Brunswick, Md.		DATE DEC 8 1966	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17155

17146

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Frederick</span> <span style="margin-left: 100px;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Frederick</span> c. LENGTH OF STAY IN 1b <span style="margin-left: 100px;">years</span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <span style="margin-left: 100px;">Frederick Nursing Center</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <span style="margin-left: 100px;">Maryland</span> <span style="margin-left: 100px;">b. COUNTY Frederick</span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Frederick</span> d. STREET ADDRESS <span style="margin-left: 100px;">704 Motter Avenue</span> e. IS RESIDENCE ON A FARM? <span style="margin-left: 100px;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span>			
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="margin-left: 100px;">Daisy</span> Middle <span style="margin-left: 100px;">Evelyn</span> Last <span style="margin-left: 100px;">Kline</span>		<b>4. DATE OF DEATH</b> Month <span style="margin-left: 100px;">December</span> Day <span style="margin-left: 100px;">10</span> Year <span style="margin-left: 100px;">19 66</span>		<b>5. SEX</b> <span style="margin-left: 100px;">Female</span>			
<b>6. COLOR OR RACE</b> <span style="margin-left: 100px;">White</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <span style="margin-left: 100px;">Dec. 11- 1878</span>		<b>9. AGE</b> (In years last birthday) <span style="margin-left: 100px;">87 yrs.</span> <b>IF UNDER 1 YEAR</b> <span style="margin-left: 100px;">Months Days Hours Min.</span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="margin-left: 100px;">House Work</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="margin-left: 100px;">Own Home</span>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <span style="margin-left: 100px;">Maryland</span>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="margin-left: 100px;">U.S.A.</span>		<b>13. FATHER'S NAME</b> <span style="margin-left: 100px;">Dr. Ephriam H. Kline</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="margin-left: 100px;">Margaret Mohler</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <span style="margin-left: 100px;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="margin-left: 100px;">220 44 5215</span>		<b>17. INFORMANT</b> Address <span style="margin-left: 100px;">Frederick- Md.</span> <span style="margin-left: 100px;">Mrs. Pauline E. Nogle-117 E. 7th. St.-</span>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 100px;">Cerebral vascular accident</span> DUE TO <span style="margin-left: 100px;">Arteriosclerotic vascular disease</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="margin-left: 100px;">(b) (c)</span> DUE TO				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="margin-left: 100px;">48 hours</span> <span style="margin-left: 100px;">8 years</span>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <span style="margin-left: 100px;">Carcinoma of the gall bladder</span>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <span style="margin-left: 100px;">19</span>			
Hour a.m. <span style="margin-left: 100px;">p.m.</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="margin-left: 100px;">20f. (City or town) (County) (State)</span>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <span style="margin-left: 100px;">July</span> <span style="margin-left: 100px;">19 66</span> <b>to</b> <span style="margin-left: 100px;">Dec 10,</span> <span style="margin-left: 100px;">19 66</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="margin-left: 100px;">Dec 10,</span> <span style="margin-left: 100px;">19 66</span> , <b>and that death occurred at</b> <span style="margin-left: 100px;">8 P.M.</span> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <span style="margin-left: 100px;">B.O. Thomas Jr</span>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <span style="margin-left: 100px;">22b. DATE SIGNED</span> <span style="margin-left: 100px;">Dec. 10-1966</span>		<b>22c. PHYSICIAN'S NAME (Type)</b> <span style="margin-left: 100px;">Dr. B.O. Thomas, Jr.</span>			
<b>22d. ADDRESS</b> <span style="margin-left: 100px;">Professional Bldg.- Frederick, Md. 21701</span>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="margin-left: 100px;">23b. DATE THEREOF</span> <span style="margin-left: 100px;">Burial</span> <span style="margin-left: 100px;">Dec. 14-1966</span>					
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <span style="margin-left: 100px;">Mt. Olivet Cemetery</span>		<b>23d. LOCATION (City, town or county) (State)</b> <span style="margin-left: 100px;">Frederick, Md. 21701</span>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="margin-left: 100px;">M.R. Etchison &amp; Son</span>		<b>25a. REC'D BY REGISTRAR</b> <span style="margin-left: 100px;">DEC 13 1966</span>		<b>25b. REGISTRAR'S SIGNATURE</b> <span style="margin-left: 100px;">Charles Judge</span>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

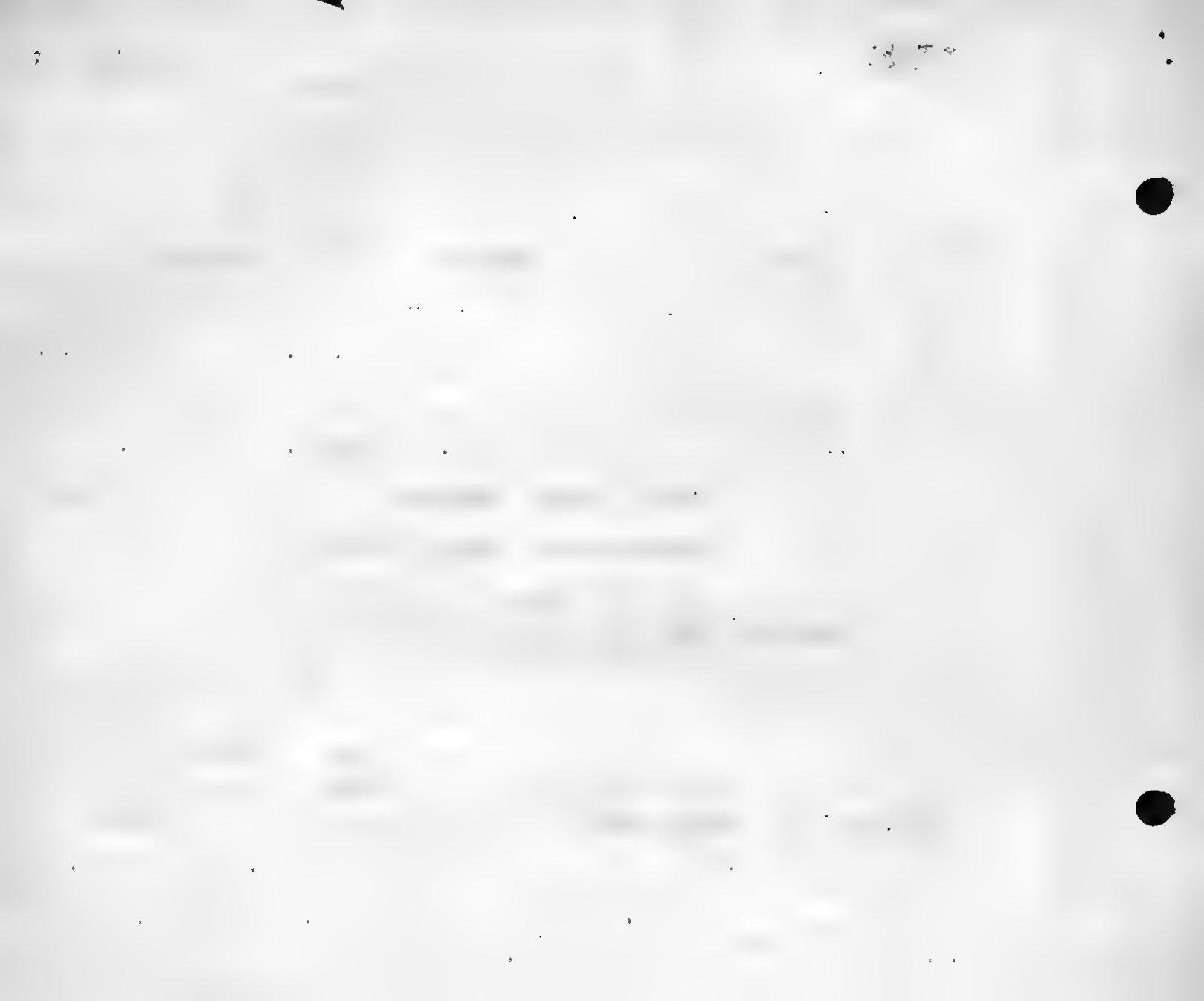
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17156

## CERTIFICATE OF DEATH

17147

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Point of Rocks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>INDIA</u> Middle <u>May</u> Last <u>LAMBERT</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17-1895</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Edward Jacob Heffner</u>				14. MOTHER'S MAIDEN NAME <u>Annie May Oden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James L. Lambert- Pt. of Rocks, Md. 21777</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hrs.</u> <u>4 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10</u> , 19 <u>62</u> , to <u>12/8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/1</u> 19 <u>66</u> , and that death occurred at <u>7:05</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard C. Reynolds</u>				M.D. <input checked="" type="checkbox"/>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <u>Richard C. Reynolds</u>				22b. DATE SIGNED <u>12/9/66</u>			
22d. ADDRESS <u>804 Toll House Ave.-Frederick, Md. 21701</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-14-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pt. of Rocks, Md. 21777</u>	
24. FUNERAL DIRECTOR <u>Edward T. M.R. Etchison &amp; Son</u>				25a. REC'D BY REGISTRAR <u>DEC 13 1966</u>			
ADDRESS <u>Whitmore</u> <u>Frederick, Md. 21701</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

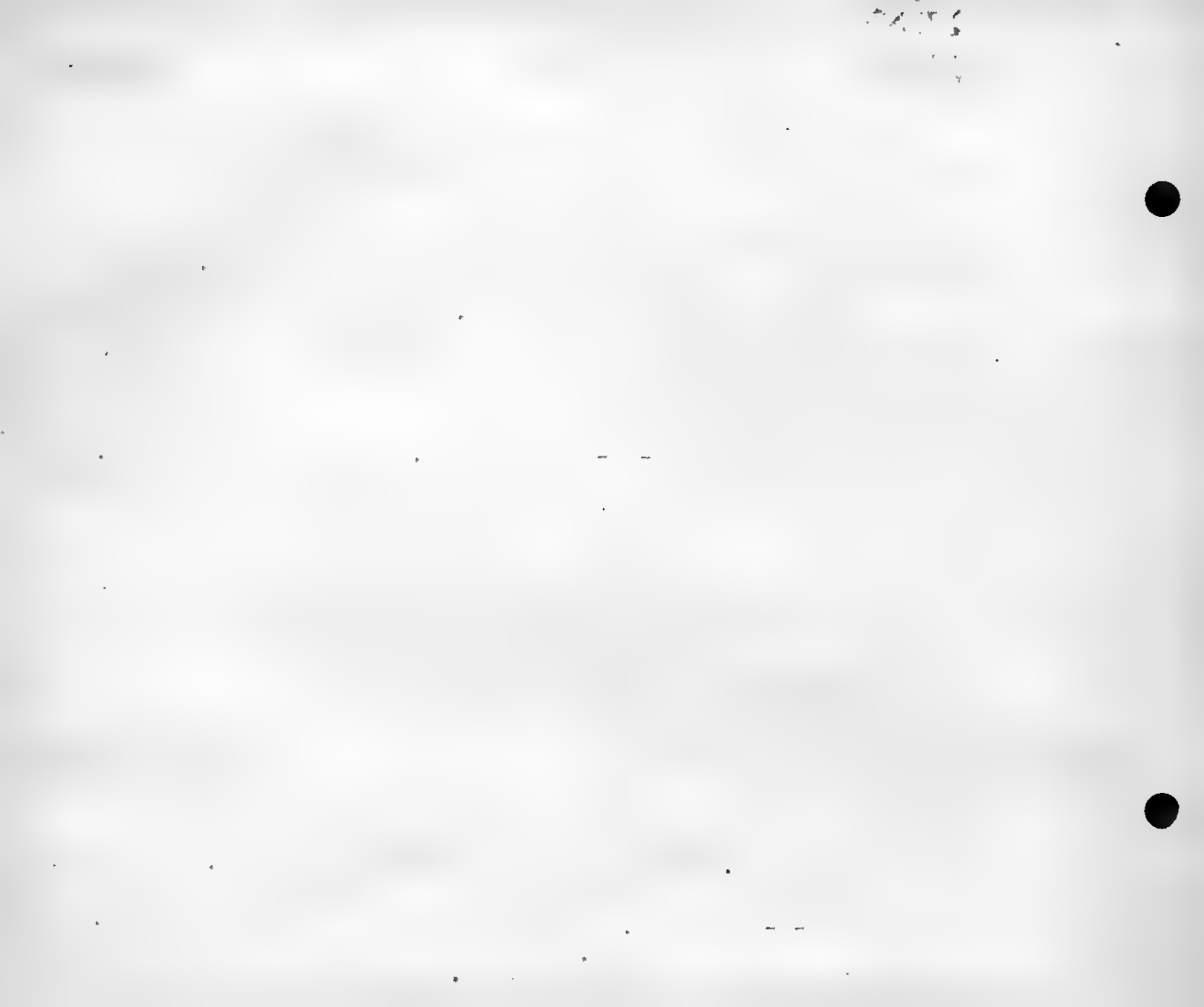
## CERTIFICATE OF DEATH

17158

17149

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Detour</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edgar Harrison Long</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 26, 1888</b>
9. AGE (In years last birthday) <b>78 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done for most of work life, even if retired) <b>Telegraph Operator</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		13. CITIZEN OF WHAT COUNTRY <b>USA</b>	
14. FATHER'S NAME <b>Charles Henry Grant Long</b>		15. MOTHER'S MAIDEN NAME <b>Amy Fox</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>705-10-8747</b>	
18. INFORMANT <b>Earl H. Long</b>		19. ADDRESS <b>Baltimore, Md. 1224 Winston Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> DUE TO (b) <b>gastric dilatation</b> DUE TO (c) <b>Paralytic ileus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert J. Thomas</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Thomas</b>		22d. ADDRESS <b>812 Toll House Ave. Frederick, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rocky Ridge Fred. Co Md</b>
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>		25. REC'D BY REGISTRAR <b>DATE JAN 3 1967</b>	
26. ADDRESS <b>Thurmont, Md.</b>		27. REGISTRAR'S SIGNATURE <b>William Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17157 CERTIFICATE OF DEATH 17148											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>100 E. Church Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Philemon</b> First <b>Smith</b> Middle <b>Lansdale</b> Last			4. DATE OF DEATH <b>December</b> Month <b>31</b> Day <b>19 66</b> Year								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 31, 1876</b>		9. AGE (In years last birthday) <b>90</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Optician</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Damascus, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Benjamin Franklin Lansdale</b>					14. MOTHER'S MAIDEN NAME <b>Emma Smith</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>214 46 5453</b>		17. INFORMANT <b>Mrs. Ruth Lansdale, (Same as item #2)</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concistive Heart Failure</b> DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Bronchiogenic Carcinoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1952</b> to <b>12-31-</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-30-1966</b> , and that death occurred at <b>9:20</b> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <b>Rex R. Martin</b> 22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M. D.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>220 N. Market St. Frederick, Maryland</b>		22b. DATE SIGNED <b>Dec. 31, 1966</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 13, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>					
24. FUNERAL DIRECTOR <b>Donald M. Fitchison</b> <b>M. R. Fitchison &amp; Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR <b>JAN 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				





15652

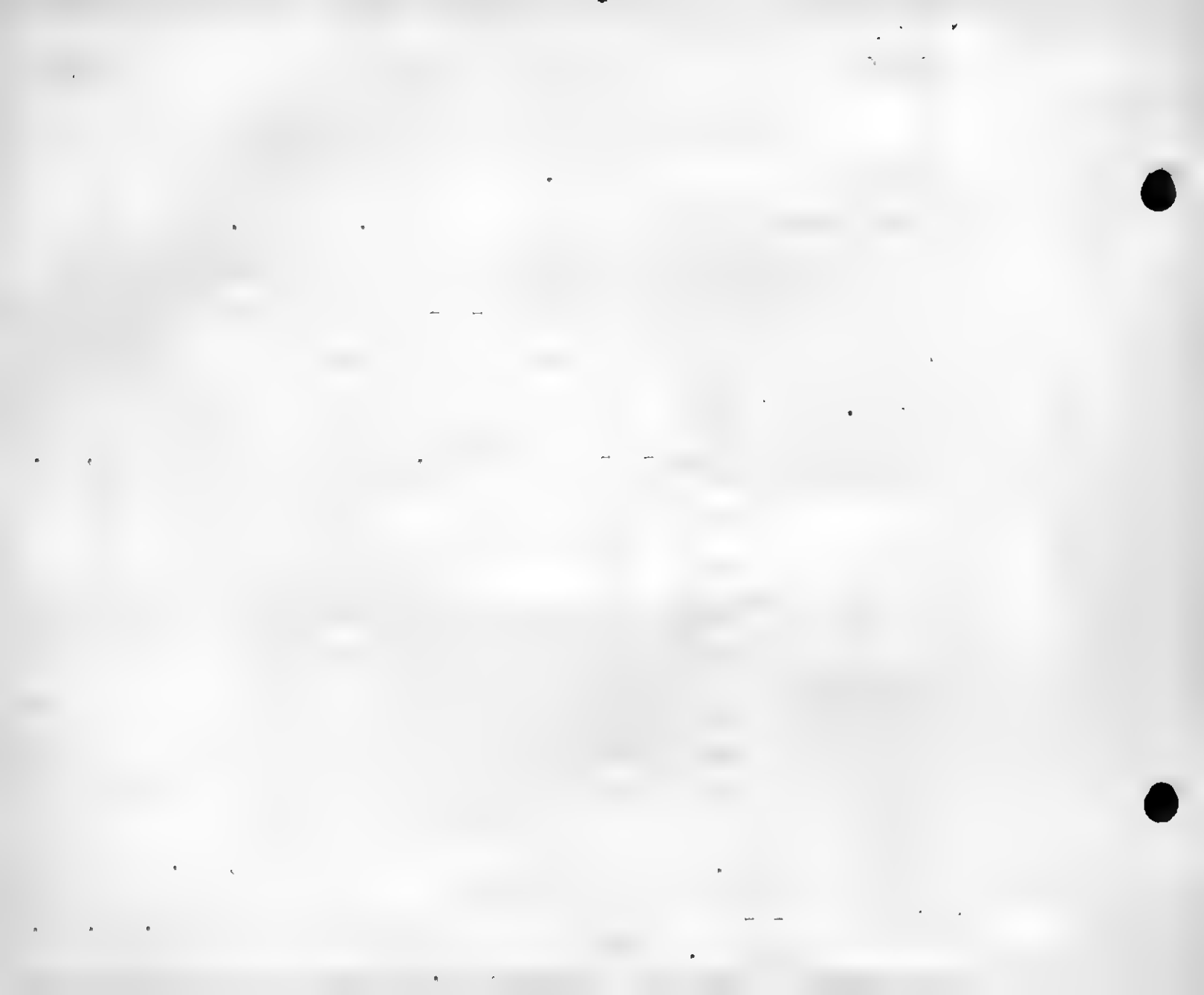
## CERTIFICATE OF DEATH

17150

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Thurmont</b>		c. LENGTH OF STAY IN 1b <b>19 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Own Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
		d. STREET ADDRESS <b>121 E. Main St.</b>	
3. NAME OF DECEASED (Type or print) <b>ROY WILLIAM LOOKINGBILL</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-24-1909</b>
9. AGE (in years last birthday) <b>57</b> yrs		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>14</b>	11. IF UNDER 24 HRS Hours <b>8</b> Min <b>00</b>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry W. Lookingbill</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Palmer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-01-2276</b>	
17. INFORMANT <b>Mable V. Lookingbill</b>		Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>acute coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>coronary atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 INH</b> <b>8 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-1-66</b> 19 <b>66</b> , to <b>12-1-66</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-1-66</b> 19 <b>66</b> , and that death occurred at <b>11P</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>Thomas A. Love</b> M.D.		22b. DATE SIGNED <b>12-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas A. Love</b>		22d. ADDRESS <b>Thurmont, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-4-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Thurmont Fred. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Raymond E. Cresser</b>		25a. REC'D BY REGISTRAR <b>DATE 05 1966</b>	
<b>Thurmont, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17159 CERTIFICATE OF DEATH 17151

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> d. STREET ADDRESS <b>10 East 'B' Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>EDWARD</b> Middle <b>MADDEN</b> Last 4. DATE OF DEATH <b>Month 12 Day 9 Year 1966</b>				5. SEX <b>M.</b> 6. COLOR OR RACE <b>W.</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>9/26/1884</b> 9. AGE (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired employee B&amp;O Railroad</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Michael Madden</b> 14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>705-05-7946</b> 17. INFORMANT <b>Lucy M. Madden Brunswick Md.</b> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebrovascular Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>12/8</b> , 19__ to <b>12/9</b> , 19__, that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Austin Pearre, Jr.</b> M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>12/9/66</b>				22c. PHYSICIAN'S NAME (Type) <b>A. Austin Pearre, Jr. M.D.</b> 22d. ADDRESS <b>Frederick Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12/12/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Petersville Md.</b>				24. FUNERAL DIRECTOR <b>Late Funeral Home</b> 25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
DATE <b>DEC 13 1966</b>							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only de a is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

17160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17152

1 PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Knoxville)</b>		c. LENGTH OF STAY IN 1b <b>10.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY MARGARET MAHONEY</b>		4. DATE OF DEATH Month Day Year <b>12 27 1966</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/26/09</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <b>57</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel B. Eagle</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Virts</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>217-12-1289</b>	
17. INFORMANT <b>Robert V. Mahoney</b>		Address <b>Knoxville Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure (Natural Causes)</b> <b>443X</b> DUE TO <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <b>Hypertensive heart disease</b> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED Where <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D.		22. DATE SIGNED <b>12/28/66</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	23b. DATE THEREOF <b>12/30/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Middletown Fred. Md.</b>
24. FUNERAL DIRECTOR <b>Teete Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17161

## CERTIFICATE OF DEATH

17153

1 PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN <b>5 1/2</b> yrs. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sabillasville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wynelle Nursing Home</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>MARY E. MANAHAN</b>		4. DATE OF DEATH <b>Dec. 15</b> 19 <b>66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Jan. 30, 1876</b>
9 AGE (In years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Royer</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Warburton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>204-30-5205</b>	
17. INFORMANT <b>Francis M. Manahan</b>		Address <b>Sabillasville Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO (b) <b>Arteriosclerotic vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>10 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>64</b> , to <b>Dec 15</b> , 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>Dec 15</b> , 19 <b>66</b> , and that death occurred at <b>3 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>LeRoy T. Davis</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12/16/66</b>
22c. PHYSICIAN'S NAME (Type) <b>LeRoy Davis</b>		22d. ADDRESS <b>Professional Bldg. N. Market St. Fredk. Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-18-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Ch. God Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Cascade Fred. Co. Md.</b>
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>		25a. REC'D BY REGISTRAR <b>Thurmont, Md</b>	25b. REGISTRAR'S SIGNATURE <b>James Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Leroy Davis

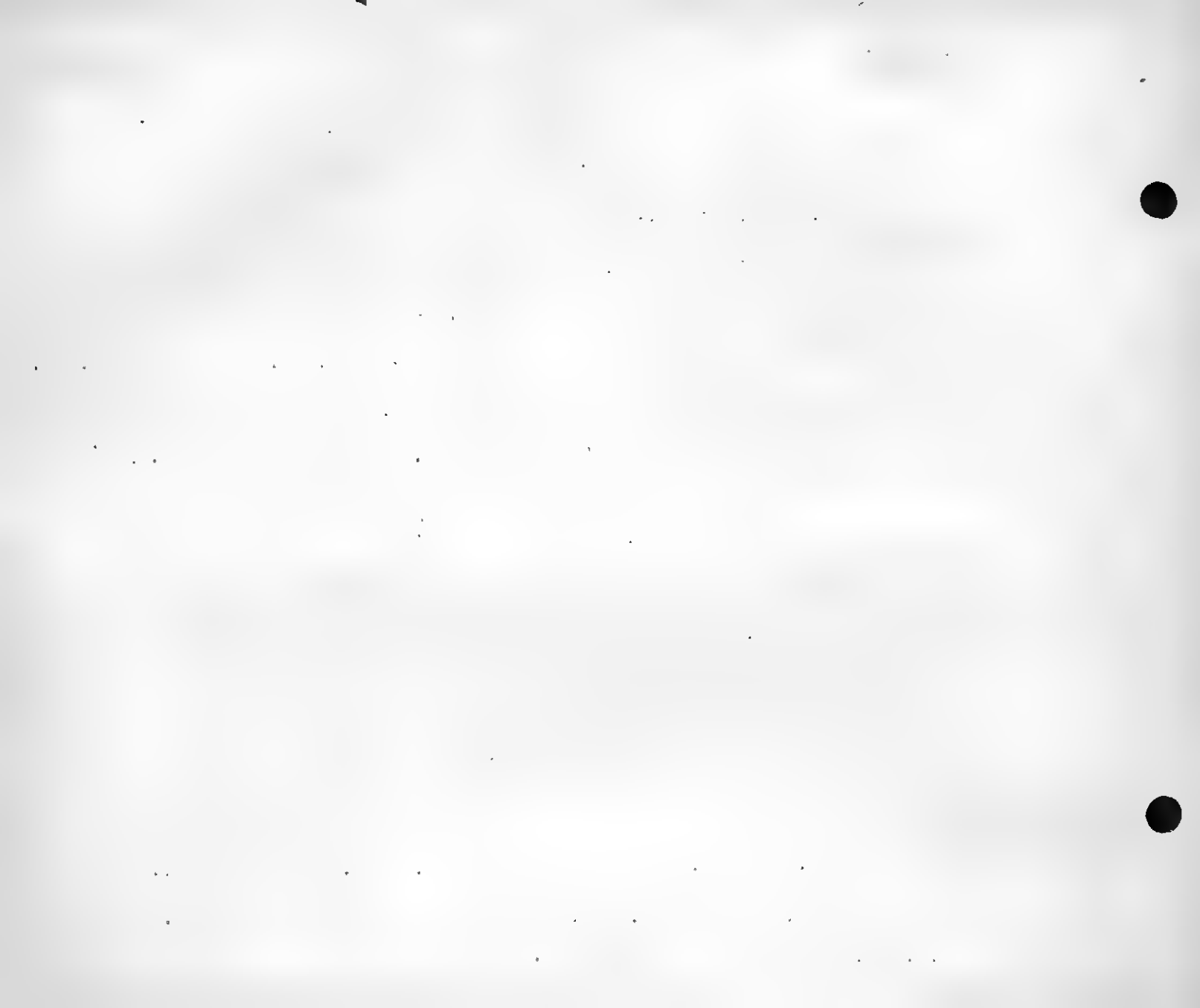
Professional Bldg. N. Market St. Fredk. Md



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17162					17154				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Frederick MARYLAND					Maryland Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Frederick				years		Frederick 12/31			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Frederick Memorial Hospital					326 Park Avenue				
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
Etta D. Michael					December 31 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White				Sept. 9 1880		86 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker				Own Home		Frederick Co. Md.		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Amos Lease					Mary Houck				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			216-46-6278		Russell L. Michael		326 Park Ave. - Frederick - Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Intestinal Obstruction DUE TO (c) Adhesions & Stenosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Heart Disease 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/1, 1965, to 12/31, 1966, that (I) (we) last saw the deceased alive on 12/31 1966, and that death occurred at 10:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE James B. Thomas					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-31-66		
22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas					22d. ADDRESS Prof. Bldg. - Frederick - Md. 21701				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		Jan. 4-1967		Mt. Olivet Cemetery		Frederick, Md. 21701			
24. FUNERAL DIRECTOR M.R. Etchison & Son					25a. REC'D BY REGISTRAR Frederick-Md. 21701		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17163 CERTIFICATE OF DEATH 17155

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>2 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montavue Co. Home for Aged</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Middletown</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Amanda E. Miller</b> First Middle Last 4. DATE OF DEATH <b>December 8, 1966</b> Month Day Year				5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>Dec. 13, 1884</b> 9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Private Homes</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John Edward Miller</b> 14. MOTHER'S MAIDEN NAME <b>Sarah Pressler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>XXXXXXXXXX</b> 17. INFORMANT <b>Miss Naomi Miller, Braddock Heights, Maryland.</b> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.3 Intestinal obstruction</b> DUE TO (b) <b>Carcinoma of the sigmoid</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 25, 1966</b> to <b>Dec 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 8, 1966</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.				22a. SIGNATURE <b>LeRoy T. Davis</b> 22b. DATE SIGNED <b>12/9/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. LeRoy T. Davis</b> 22d. ADDRESS <b>Frederick, Md.</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12/11/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Middletown, Fred. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Gladhill Company, Middletown, Maryland</b> ADDRESS				25a. REC'D BY REGISTRAR <b>DEC 12 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17164

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17156

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY in lb <b>years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>535 Wilson Place</b>		e. STREET ADDRESS <b>535 Wilson Place</b>	
3. NAME OF DECEASED (Type or print) First <b>Iva</b> Middle <b>Lee</b> Last <b>Moon</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18-1905</b>
9. AGE (in years last birthday) <b>61</b>		10. FUND 1 YEAR Months <b>26</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dominick Avella</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Purnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-20-3018</b>	
17. INFORMANT <b>Truman W. Moon-535 Wilson Place-Frederick-</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>350A</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Aspiration Asphyxia- Gastric Contents</b> DUE TO (c) <b>Ruptured Aneurism- Circle of Willis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b> EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		22. DATE SIGNED <b>Dec. 26-1966</b> Frederick, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 29-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Frederick, Md. 21701</b>	
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>		25. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
ADDRESS <b>Frederick, Md. 21701</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.



17165

## CERTIFICATE OF DEATH

17157

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> <u>MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> <u>RURAL</u> <u>MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MOLLIE</u> <u>SNADER</u> <u>NICODEMUS</u>		4. DATE OF DEATH Month Day Year <u>DEC</u> <u>12</u> <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 4 - 1930</u> <u>SC</u>
9. AGE (In years last birthday) _____ yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CWN HOME</u>	
11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN T. SNADER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH CLEMSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-34-6008</u>	
17. INFORMANT <u>ELI NICODEMUS</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) _____			
DUE TO _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <u>arteriosclerotic CVD</u>			
DUE TO _____			
(c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/11/64</u> , 19 <u>64</u> , to <u>12/12/66</u> , that (I) (we) lost saw the deceased alive on <u>12/16/66</u> 19 <u>66</u> , and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Robertson</u>		22b. DATE SIGNED <u>12/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>		22d. ADDRESS <u>New Windsor, Md.</u>	
23a. BURIAL, CREMATION, --REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/15/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		23d. LOCATION (City or Town) (County) (State) <u>UNIONVILLE MD</u>	
24. FUNERAL DIRECTOR <u>R. H. Hartman &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>DEC 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. H. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





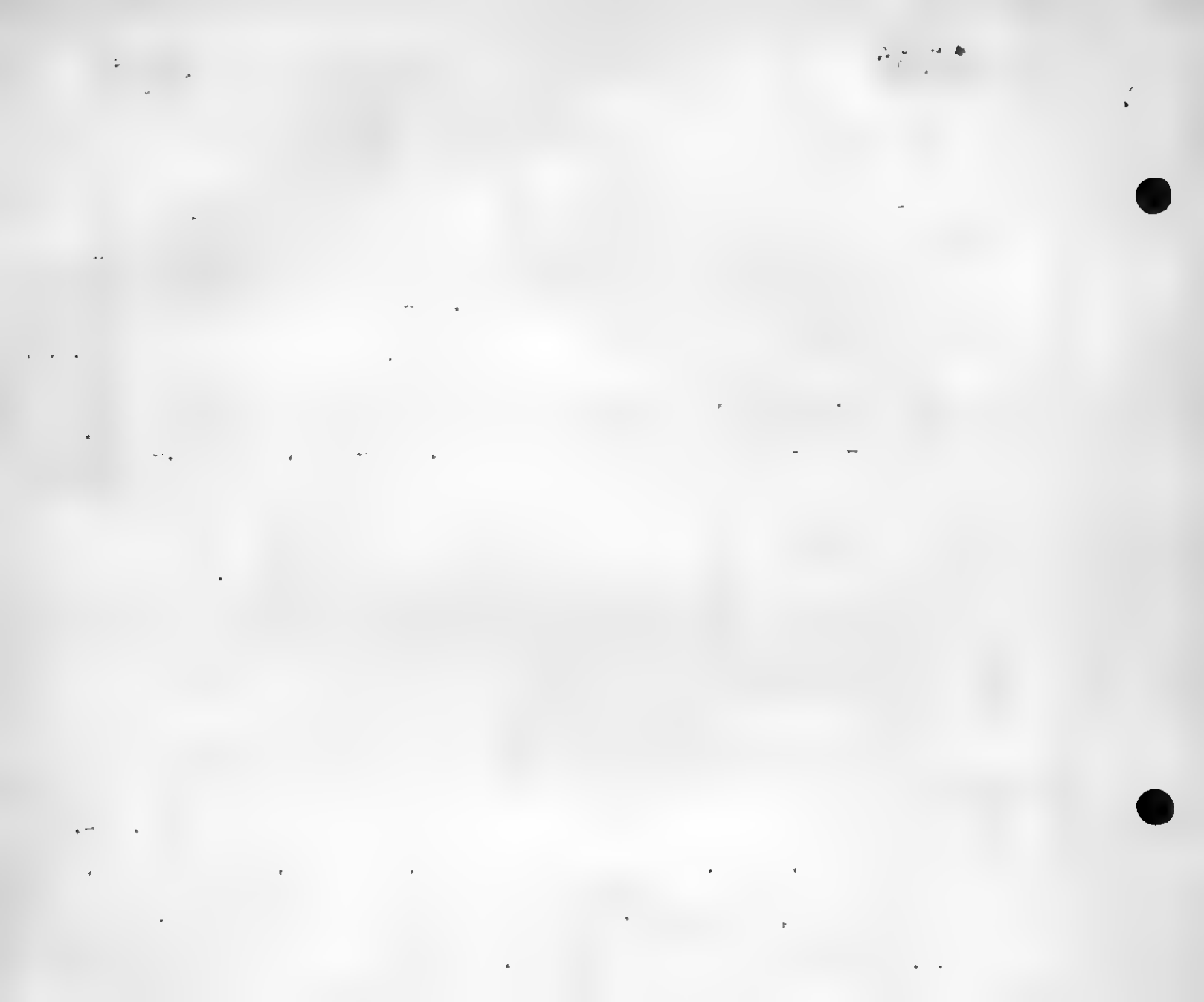
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**17166** **CERTIFICATE OF DEATH** **17158**

1. PLACE OF DEATH e. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DOA- Frederick Memorial Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>459 West South St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Middle Last Sherman Summerfield Orem</b>				4. DATE OF DEATH <b>Month Day Year December 24- 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11-1895</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nimrod S. Orem, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Florence Marsh</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Nimrod S. Orem-459 W. South St.- Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, terminal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>IX</b> DUE TO (b) <b>Hypertensive arteriosclerotic cerebral + cardiac vascular disease</b> DUE TO (c) <b>Cerebral hemorrhage &amp; thrombosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>10 years</b> <b>6-8 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>12-23-1966</b> , to <b>12-24-1966</b> , that (I) (we) last saw the deceased alive on <b>12-23-1966</b> , and that death occurred at <b>7A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Rex R. Martin</b>				22b. DATE SIGNED <b>Dec. 24-1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin</b>		22d. ADDRESS <b>220 N. Market St.- Frederick, Md. 21701</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)				
<b>Burial</b>	<b>Dec. 27-1966</b>	<b>Mt. Olivet Cemetery</b>	<b>Frederick, Md. 21701</b>				
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>		ADDRESS <b>Frederick, Md. 21701</b>	25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

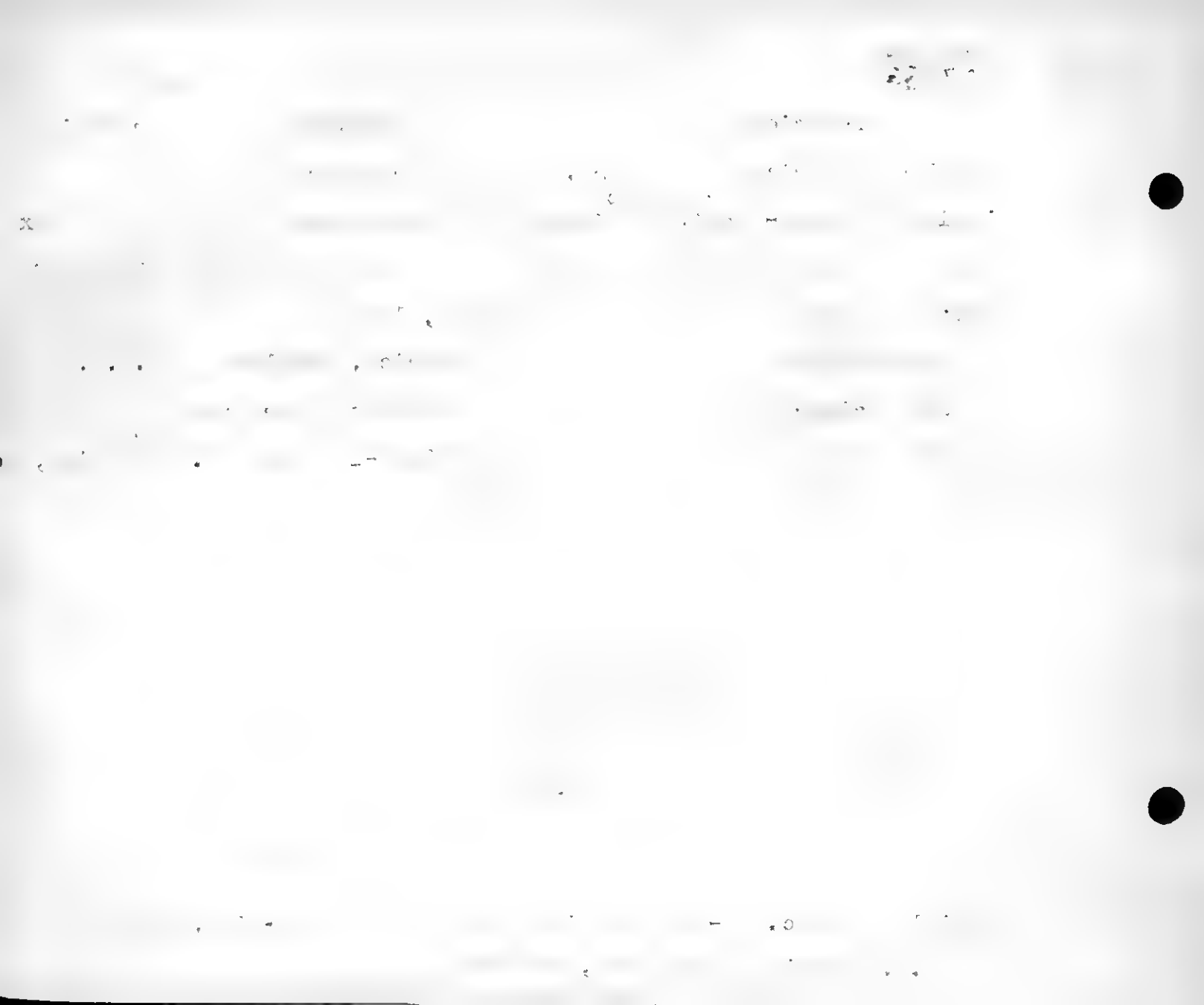


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only event within 72 hours after death.

FOR STATE HEALTH DEPT.

<div>Item 20 Film 384 1-3-67 a MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>17167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17159</div>											
1 PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Frederick</b>				c. LENGTH OF STAY IN 1b <b>hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in home, write address) <b>Reels Mill Road- Louis Battistone</b>						d. STREET ADDRESS <b>116 East Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>BARRY LYNN PALMER</b>						4 DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 9, 1961</b>		9. AGE (In years last birthday) yrs <b>5</b>		10. UNDER 1 YEAR Months <b>1</b> Days <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>*****</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Palmer</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Morrison</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Maryland</b> <b>John Palmer-116 East St. Frederick, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>1190 IMMEDIATE CAUSE (a) DROWNING</b> <b>1210</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Slidin' down hill, when on a pond - sled broke on the ice and he was caught under the ice.</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11:20</b> <b>pm</b> <b>Dec 23 1966</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Pond</b>		20f. (City or town) (County) (State) <b>Frederick Fred. Md.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED		
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <b>12/23/66</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 25-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>			
24. FUNERAL DIRECTOR <b>C.E. Hicks 111 Frederick, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



FOR STATE  
HEALTH DEPT.

17168

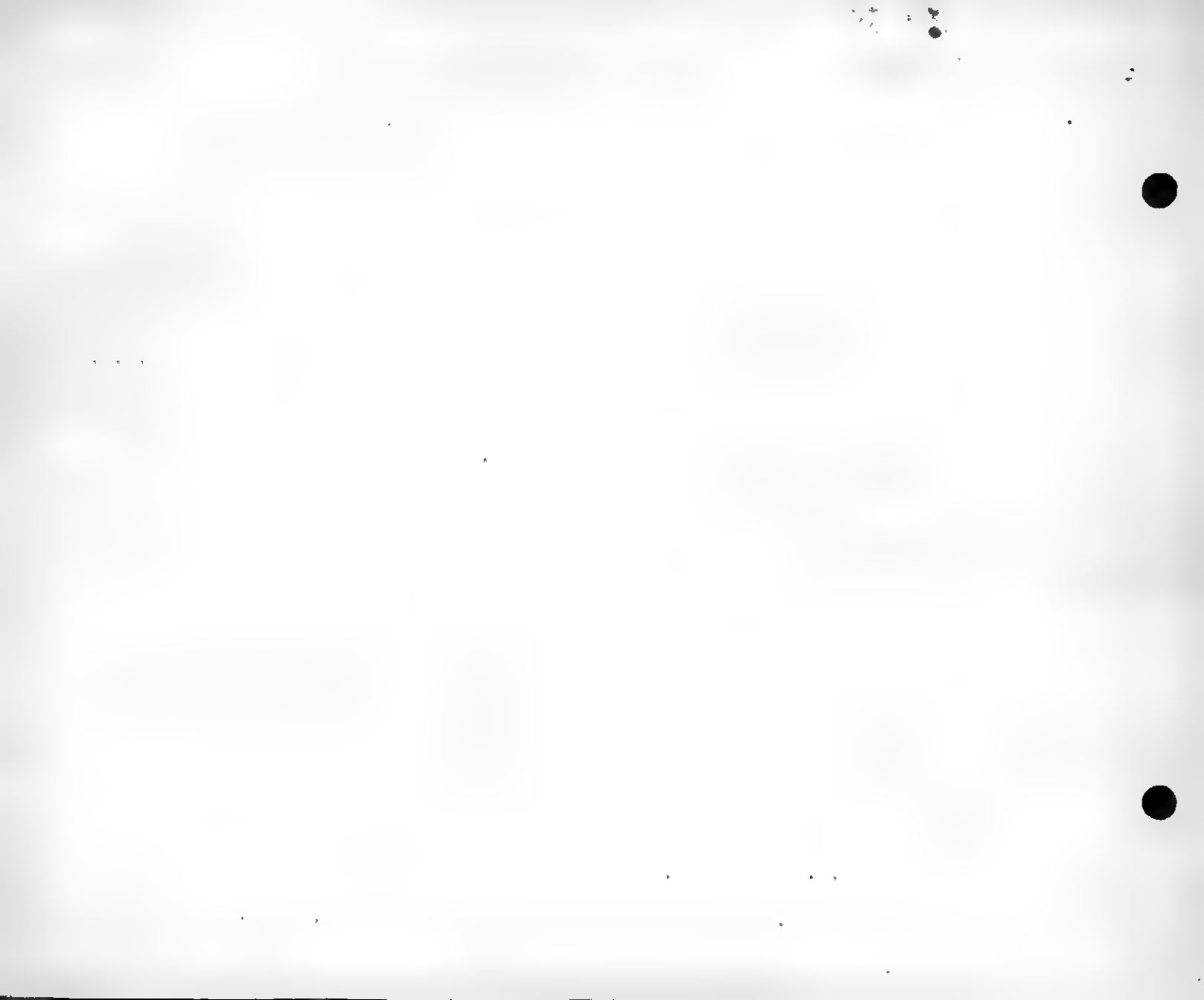
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17160

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb Hours <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rear 602 Trail Avenue</b>		d. STREET ADDRESS <b>249 West Fifth Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Douglas Clifford Paust</b>		4. DATE OF DEATH Month Day Year <b>December 15- 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1949</b>
9. AGE (In years lost birthday) yrs. <b>17</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Pauline Baker</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214 48 2852</b>		17. INFORMANT <b>Mrs. Pauline Kline (Same as item # 2)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>891.6</b> IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Carbon monoxide poisoning, with car running in close garage</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12, 15, 1966</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Garage</b>	20f. (City or town) (County) (State) <b>Frederick, Frederick Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>12-15-1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 17, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Mem. Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Nr. Hansonville, Md</b>	
24. FUNERAL DIRECTOR <b>M. R. Echison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

17169

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17161

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY - in 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>128 West Patrick Street</b>		e. STREET ADDRESS <b>128 West Patrick Street</b>	
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>L.</b> Last <b>PERKINS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 April 1926</b>
9. AGE (In years past birthday) yrs <b>40</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Harry T. Perkins</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Himes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>212 14 6470</b>	
17. INFORMANT <b>Harry T. Perkins</b>		18. ADDRESS <b>404 N. Bentz St. Frederick, Md. 21701</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>Massive fatty infiltration of liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic alcoholism and idiopathic epilepsy</b> (c) <b>Early cirrhosis of liver</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D. EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>12-7-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/10/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Frederick, Md. 21701</b>
24. FUNERAL DIRECTOR <b>Frank R. Smith</b> ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Md. 21701</b>		25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

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17170

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17162

1. PLACE OF BIRTH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Mt. Airy</b>		c. LENGTH OF STAY IN Ia <b>22 Years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before arrival on) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Mt. Airy</b>		d. STREET ADDRESS <b>R. D. 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>ELAINE</b> Last <b>PERRY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1966</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. B. DATE OF BIRTH <b>March 21, 1903</b>		9. AGE (in years last birthday) yrs <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Ensor</b>		14. MOTHER'S MAIDEN NAME <b>Mary McFatridge</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>212-14-0722</b>		17. INFORMANT <b>Mrs. Ethel Merryman</b> Address <b>2228 Keswick Rd. Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Defensive homicide</b> DUE TO <b>Acute congestive heart failure</b> (b) <b>acute poisoning</b> DUE TO <b>Acute alcoholism</b> (c) <b>Exposure to freezing temperature</b>		19. INTERVAL BETWEEN ONSET AND DEATH		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour: 0 m p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
23. ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D.		23b. EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr. M.D.</b>		23c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		23d. ADDRESS (Street, city, town, or county)		22. DATE SIGNED <b>12-5-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/8/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Leisters Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Carroll Co., Md.</b>		24. FUNERAL DIRECTOR <b>C. M. Waltz</b> Address <b>Box 241 Shesville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



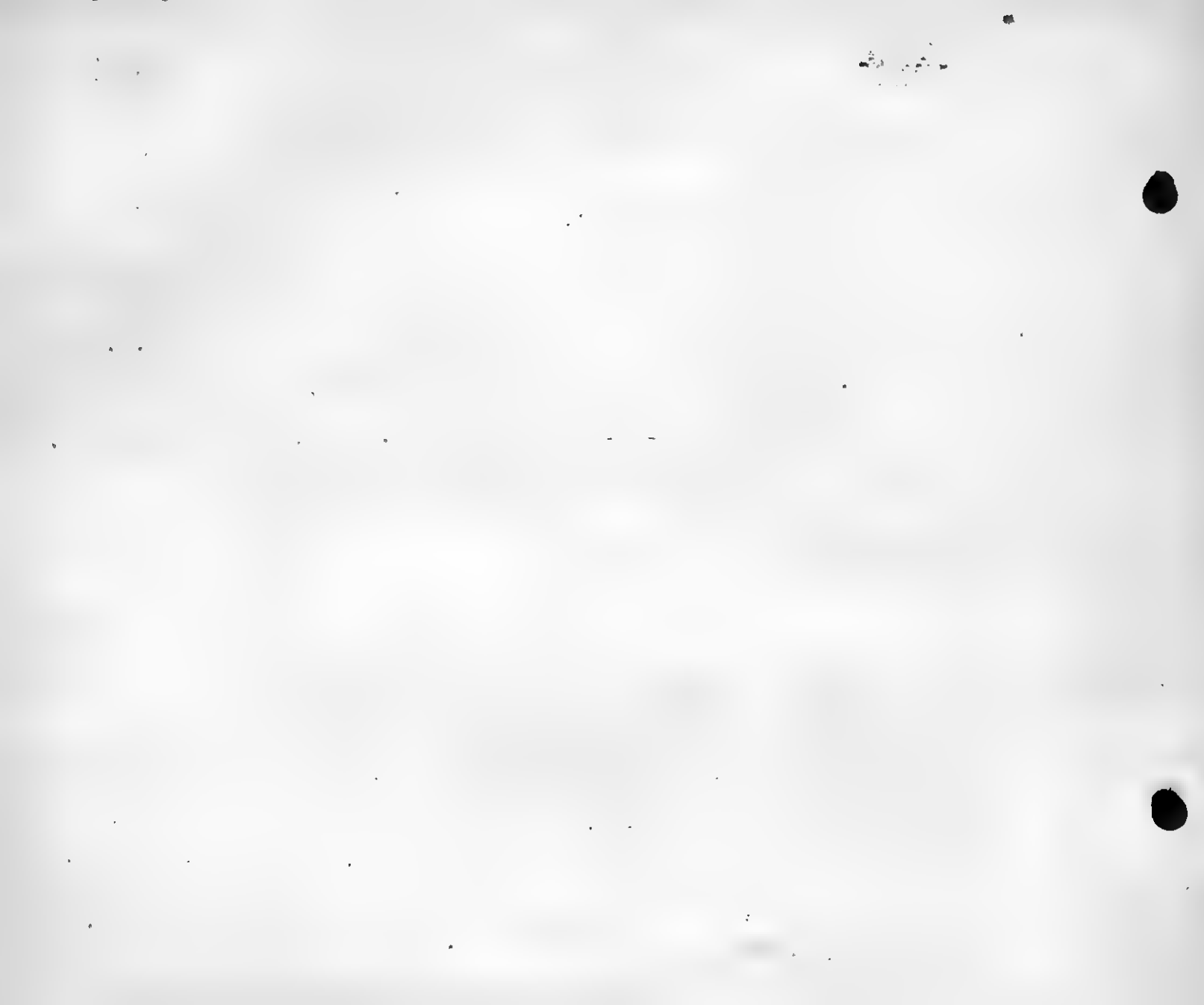
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>17171</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>17163</p> </div> </div>																			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Frederick</b> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b></p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b></p> <p>d. STREET ADDRESS <b>517 East Potomac St.</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>														
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <b>Loretto</b> Middle <b>Elizabeth</b> Last <b>Phillips</b></p>			<p>4. DATE OF DEATH</p> <p>Month <b>Dec</b> Day <b>11</b> Year <b>1966</b></p>		<p>5. SEX <b>F</b></p>			<p>6. COLOR OR RACE <b>W</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>6/2/1904</b></p>		<p>9. AGE (In years last birthday) <b>62</b> yrs.</p>		<p>IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>					<p>10b. KIND OF BUSINESS OR INDUSTRY</p>					<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Virginia</b></p>					<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b></p>				
<p>13. FATHER'S NAME <b>Silas A. Smith</b></p>					<p>14. MOTHER'S MAIDEN NAME <b>Elizabeth M. Horan</b></p>														
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)</p>					<p>16. SOCIAL SECURITY NO. <b>226-09-9798</b></p>					<p>17. INFORMANT <b>Carroll D. Phillips</b> Address <b>Brunswick Md.</b></p>									
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Extensive pulmonary metastases</b></p> <p>110X DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of breast</b></p> <p>DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b></p>														<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>6 mo.</b></p> <p><b>3 yrs</b></p>					
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>									<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. <b>19</b></p>					<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>					<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>					<p>20f. (City or town) (County) (State)</p>				
<p>21. I certify that (I) (this hospital) attended the deceased from <b>Dec 4</b>, 1966, to <b>Dec 11</b>, 1966, that (I) (we) last saw the deceased alive on <b>Dec 11</b>, 1966, and that death occurred at <b>7:30 A</b> M, from the causes and on the date stated above.</p>																			
<p>22a. SIGNATURE <b>Henry V. Chase</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>														<p>22b. DATE SIGNED <b>11 Dec '66</b></p>					
<p>22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b></p>														<p>22d. ADDRESS <b>804 Toll House Ave, Frederick, Md</b></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>					<p>23b. DATE THEREOF <b>12/14/66</b></p>					<p>23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery Winchester Va.</b></p>					<p>23d. LOCATION (City, town or county) (State)</p>				
<p>24. FUNERAL DIRECTOR <b>Frederick Funeral Home</b></p>														<p>25a. REC'D BY REGISTRAR <b>DEC 14 1966</b></p>		<p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>			

MEDICAL CERTIFICATION



171722

## CERTIFICATE OF DEATH

17164

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Own Home</b>		d. STREET ADDRESS <b>E. MAIN ST</b>	
3. NAME OF DECEASED (Type or print) <b>Elmer J. Pittinger</b>		4. DATE OF DEATH <b>December 30 1966</b>	
5. SEX <b>Male</b>	6. CO. OR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11, 1881</b>
9. AGE (In years last birthday) <b>85</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance of Ways W.M. Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woodsboro, Maryland</b>	
11. BIRTHPLACE (County & State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Washington Pittinger</b>		14. MOTHER'S MAIDEN NAME <b>Elezabeth Engle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-7012</b>	
17. INFORMANT <b>Mrs. Ethel Pittinger Thurmont, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease arterio-sclerotic type</b> DUE TO (b) <b>Arterio-sclerosis - generalized</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 23, 1966</b> , to <b>Dec 30, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec 30, 1966</b> , and that death occurred at <b>9 p.m.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>James K. Gray</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		22d. ADDRESS <b>12-E Main Thurmont Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 2, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Taber</b>		23d. LOCATION (City or Town) (County) (State) <b>Rocky Ridge Md. FredCo</b>	
24. FUNERAL DIRECTOR <b>Raymond E. Greager</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



17173

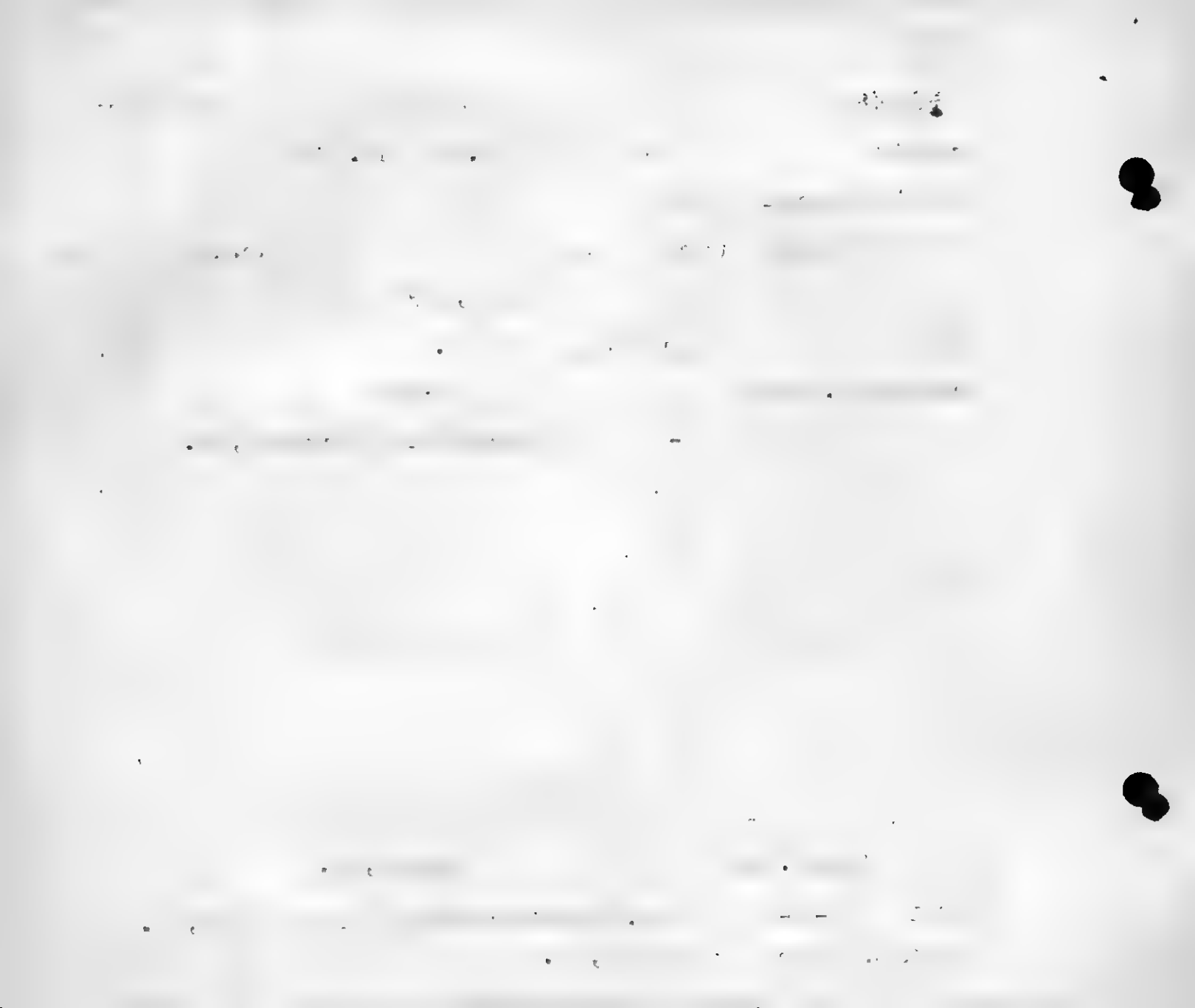
## CERTIFICATE OF DEATH

Reg. Dist. No. 17165

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial DOA</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Granville</b> Middle <b>(None)</b> Last <b>Poole</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> Year <b>1966</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1891</b>	
9. AGE (In years lost birthday) <b>75</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Greenberry C. Poole</b>				14. MOTHER'S MAIDEN NAME <b>Ida Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT <b>Monroe Poole Frederick, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Pulmonary edema</b> (b) <b>Pulmonary edema</b> (c) <b>Pulmonary edema</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>4 years</b> <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>10/21</b> , 19 <b>60</b> , to <b>12/22</b> , 19 <b>66</b> , that I last saw the deceased alive on <b>12/22</b> , 19 <b>66</b> , and that death occurred at <b>Md.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DAMASCUS, MD.</b> DATE SIGNED <b>12/23/66</b> ACTUAL SIGNATURE <b>James P. Kerr</b> M.D. <b>DAMASCUS, MD.</b> PHYSICIAN'S NAME (Type) <b>James P. Kerr</b> <b>Damascus, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-24-66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mont. Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Claggetttsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. J. G. 22</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

17174

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17166

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN Id <b>XXXXX</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>319 East 2nd Street</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>POPLO</b> Last		4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1915</b>
9. AGE (In years, months, days) <b>51</b>		IF UNDER 1 YEAR Months <b>51</b> Days <b>31</b>	IF UNDER 24 HRS Hours <b>31</b> Min. <b>31</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garage Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Bysville, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Poplowski</b>		14. MOTHER'S MAIDEN NAME <b>Anna Osage</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>705-12-5720</b>	
17. INFORMANT <b>Mrs. Evelyn P. Poplo</b>		Address <b>319 E. 2nd St. Fred. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fractured Spine; Transected Spinal Cord;</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Curved Atria of Heart; Crushed Chest</b> (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Hit by train</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12-9-1966</b> p.m. <b>9</b>		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) <b>Frederick - Frederick - Md</b>		20f. (City or town) (County) (State) <b>Frederick - Frederick - Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D.		22. DATE SIGNED <b>12-9-66</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, Sr., M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frostburg, Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert E. Dailey &amp; Son</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 12 1966</b>	
Address <b>Frederick, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any, or if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>17175</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div>17167</div> </div>																				
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN b. <b>2 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pleasantville (Rural)</b> d. STREET ADDRESS <b>Hoffmaster Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print) First <b>HARRY</b> Middle <b>LEE</b> Last <b>REID</b>			<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>13</b> , Year <b>1966</b>			<b>5. SEX</b> <b>Male</b>			<b>6. COLOR OR RACE</b> <b>White</b>			<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>Aug. 16, 1876</b>			<b>9. AGE</b> (In years last birthday) <b>90</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck Farmer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pleasantville, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>								
<b>13. FATHER'S NAME</b> <b>Daniel Milton Reid</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Susan Sabinia Mitchell</b>														
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>				<b>16. SOCIAL SECURITY NO.</b> <b>232-80-3842</b>				<b>17. INFORMANT</b> <b>Wm. B. Pollitt, RFD#1, Harpers Ferry, W. Va.</b>												
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO (b) <b>uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b>								
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)														
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.						<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)										
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>19</b> <b>to</b> <b>19</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>19</b> , <b>and that death occurred at</b> <b>M</b> , <b>from the causes and on the date stated above.</b>																				
<b>22a. SIGNATURE</b> <b>A. Austin Pearre, Jr.</b>												<b>22b. DATE SIGNED</b> <b>12/13/66</b>								
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>A. Austin Pearre, Jr.</b>						<b>22d. ADDRESS</b> <b>Frederick, Maryland</b>														
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>12/16/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Samples Manor Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Samples Manor, Maryland</b>										
<b>24. FUNERAL DIRECTOR</b> <b>A. Donald Ziebler</b>						<b>ADDRESS</b> <b>Harpers Ferry, W. Va.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE DEC 21 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>W. B. Judge</b>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
171176 CERTIFICATE OF DEATH 171168											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> 101					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>						d. STREET ADDRESS <b>624 Wilson Place</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Kline</b> Last <b>Ridgely</b>						4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 27-1902</b>		9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Secretary</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Wm. Kline</b>						14. MOTHER'S MAIDEN NAME <b>Mollie Crum</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-24-2103</b>		17. INFORMANT Address <b>Frederick-Md.</b> <b>Mrs. Alvin S. Klein-624 Wilson Place-</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Renal failure</b> DUE TO (c) <b>Arteriosclerosis Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Peripheral Vascular Disease</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1966</b> , to <b>12-28, 1966</b> , that (I) (we) last saw the deceased alive on <b>12-28-1966</b> , and that death occurred at <b>3p.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert J. Thomas</b>						22b. DATE SIGNED <b>12/28/66</b>			22c. PHYSICIAN'S NAME (Type) <b>Dr. Robt. J. Thomas</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-31-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Frederick, Md. 21701</b>		
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
26. ADDRESS <b>Frederick, Md. 21701</b>						27. DATE <b>JAN 3 1967</b>					



17177

## CERTIFICATE OF DEATH

17169

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>Route #1 Mt. Airy</u>	
3. NAME OF DECEASED (Type or print) <u>Stella Mae Rautzahn</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-12</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Oscar Green</u>		14. MOTHER'S MAIDEN NAME <u>Dolly Hurd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Lorraine Bowser</u>		Address <u>Route #1 Mount Airy</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 5870 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Acute Diffuse Peritonitis</u> (c) <u>Acute Hemorrhagic Pancreatitis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-30-66</u> , 19 <u>66</u> , to <u>12-3</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12-3</u> , 19 <u>66</u> , and that death occurred at <u>10:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G F MEADORS</u>		22b. DATE SIGNED <u>12-3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G F MEADORS</u>		22d. ADDRESS <u>Frederick, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/6/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>E.U.B. Cemetery, Pleasant</u>	23d. LOCATION (City or Town) (County) (State) <u>Frederick Co. Md.</u>
24. FUNERAL DIRECTOR <u>Gladhill Company, Middletown, Maryland</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in compliance within 72 hours after death.

VR A15ME (5)  
GM 1/66

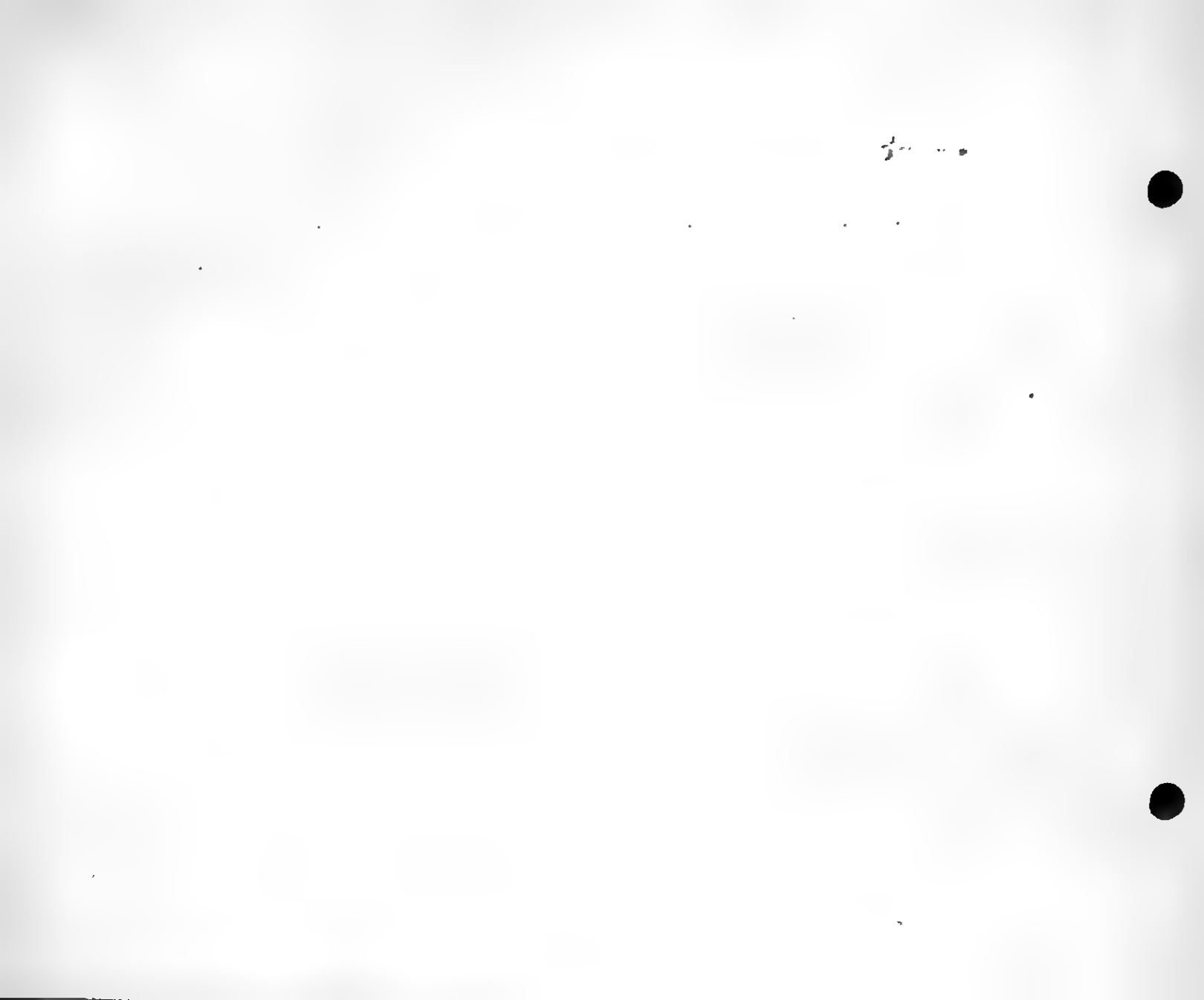
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17170

1 PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Lantz</b> c. LENGTH OF STAY IN 1b <b>10 yrs.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Lantz</b> d. STREET ADDRESS <b>Wise Rd., Lantz R. D. 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Ruth May Schlipper</b>		4 DATE OF DEATH Month Day Year <b>Dec. 3 1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 7, 1907</b>
9 AGE (In years last birthday) <b>59 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Min <b>59</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Joseph B. McAlister</b>		14 MOTHER'S MAIDEN NAME <b>Virginia Noel</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		16 SOCIAL SECURITY NO <b>unknown</b>	
17 INFORMANT <b>Mr. Wilmer H. Schlipper</b>		Address <b>Baltimore 7 Md. 3621 Etemiller Rd.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY <b>976X</b> IMMEDIATE CAUSE (a) <b>Self inflicted gun shot wound Rt. Temple</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Immediate</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Frederick, Md.</b>	
22. DATE SIGNED <b>12/3/66</b>			
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Dec. 6, 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Nathan Z. Grove</b>		ADDRESS <b>Waynesboro, Pa.</b>	
25a REC'D BY REGISTRAR <b>DEC 7 1966</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



17179

## CERTIFICATE OF DEATH

17171

1 PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Brederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Creagerstown</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Own Home</b>		d. STREET ADDRESS <b>Thurmont RD</b>	
3. NAME OF DECEASED (Type or print) <b>SUSAN CORNELIA SHORB</b>		4 DATE OF DEATH <b>Dec. 13 19 66</b>	
5. SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9 AGE (In years last birthday) <b>82</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Levi Baltzell</b>		14 MOTHER'S MAIDEN NAME <b>Mary Sheld</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-54-0898</b>	
17. INFORMANT <b>Charles A. Shorb</b>		Address <b>Creagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive failure</b> 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic obstructive cardiovascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4-5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 1957, to <b>Dec. 13, 1966</b> , that (I) (we) lost saw the deceased alive on <b>Dec. 11, 1966</b> , and that death occurred at <b>9 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>E. A. Dettbarn</b>		22b. DATE SIGNED <b>12/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. A. DETTBARN</b>		22d. ADDRESS <b>Walkerville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-17-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Thurmont Fred. Co. Md.</b>
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
ADDRESS <b>Thurmont, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17180  
17172  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural- Union Bridge</b> d. STREET ADDRESS <b>Route 2, Union Bridge</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>James</b> First <b>Simmons</b> Middle <b>Simmons</b> Last <b>JAMES SIMMONS</b>		4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1966</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1898</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>5</b> Hours <b>1</b> Min. <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Poolesville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Daniel Webster Simmons</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Mae Jackson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>W. W. # 1</b>		16. SOCIAL SECURITY NO. <b>216 44 6881</b>		17. INFORMANT <b>Mrs. Mary Simmons (Same as item #2)</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE RECTUM WITH</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTASES TO THE LIVER AND</b> DUE TO (c) <b>PERIAORTIC NODES</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3-4 months</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (1) this hospital attended the deceased from <b>11/8</b> , 19 <b>66</b> , to <b>12/5</b> , 19 <b>66</b> that (2) (we) last saw the deceased alive on <b>12/5</b> , 19 <b>66</b> , and that death occurred at <b>9:27 AM</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>Richard C. Reynolds</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/5/66</b>
22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds, M.D.</b>				22d. ADDRESS <b>Toll House Ave. Frederick, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>
24. FUNERAL DIRECTOR <b>Donald M. H. R. Atchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR <b>DEC 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

17181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17173

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not inst. on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY N 1b <u>D.C.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick City Hospital</u>		d. STREET ADDRESS <u>19 Devonshire</u>	
3 NAME OF DECEASED (Type or print) <u>WILLIAM HENRY SMITH Sr</u>		4 DATE OF DEATH <u>Dec 3 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10 1903</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Supt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cyl. Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Truman P. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO <u>11-15-1011</u>	
17. INFORMANT <u>Mrs Beatrice Smith</u>		Address <u>19 Devonshire</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 816.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Massive Subdural Hemorrhage</u> DUE TO (c) <u>Fractured Skull</u>		19. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A JUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Truck-Auto Collision</u>	
20c. TIME OF INJURY Month, Day, Year <u>6</u> Hour <u>pm</u> <u>12-3 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.) <u>Highway</u>		20f. (City or town) <u>Point of Rocks - Frederick Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas, Sr. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12/7/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>DEC 3 1966</u>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17182					17174				
1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>			c. LENGTH OF STAY IN 1b <i>9 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brunswick</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Frederick Memorial Hospital</i>					d. STREET ADDRESS <i>10 N. Maryland Ave</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>JOHN FRANKLIN SNEED</i>					4. DATE OF DEATH Month Day Year <i>DECEMBER 10, 1966</i>				
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/5/97</i>		9. AGE (in years last birthday) <i>69</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer - B &amp; O R.R. (Ret)</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jim Sneed</i>					14. MOTHER'S MAIDEN NAME <i>Nerrie A. Housley</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <i>403-07-080</i>		17. INFORMANT Address <i>John F. Sneed Jr Brunswick Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHOGENIC CARCINOMA</i> <i>162.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <i>11/30</i> , 19 <i>66</i> , to <i>12/10/66</i> , 19 <i>66</i> , that (2) we last saw the deceased alive on <i>12/9</i> , 19 <i>66</i> , and that death occurred at <i>12 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Richard C. Reynolds</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <i>12/10/66</i>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Richard C. Reynolds, MD</i>				22d. ADDRESS <i>Frederick Md.</i>					
23a. BURIAL, CREMATION, (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/14/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>			23d. LOCATION (City, town or county) (State) <i>Fort Myer Virginia</i>		
24. FUNERAL DIRECTOR <i>Fetter Funeral Home</i>				ADDRESS <i>Brunswick Maryland</i>		25a. REC'D BY REGISTRAR <i>DEC 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17183

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17175

1 PLACE OF DEATH a COUNTY <b>Frederick</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c LENGTH OF STAY IN 1b <b>Years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		d STREET ADDRESS <b>411 Delaware Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Roscoe</b> Middle <b>Conklin</b> Last <b>Spurrier</b>		4 DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 28-1881</b>
9 AGE (in years last birthday) <b>85</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b KIND OF BUSINESS OR INDUSTRY <b>City Park Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Hansen Spurrier</b>		14 MOTHER'S MAIDEN NAME <b>Mary Burton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-5190A</b>	
17 INFORMANT <b>Mr. W.M. Ray Spurrier-411 Delaware Rd.</b>		Address <b>Frederick, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. <b>570.5</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Intestinal Obstruction-Ileus</b> DUE TO (c) <b>Fractured Hip</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <b>0.m.</b> p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b> MD		22. DATE SIGNED <b>12-28-1966</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Frederick, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>12-30-1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Frederick Mem. Park</b>	23d LOCATION (City or town) (County) (State) <b>W. of Frederick, Md. 21701</b>
24 FUNERAL DIRECTOR <b>Edward T. M.R. Etchison &amp; Son</b>		ADDRESS <b>Frederick, Md. 21701</b>	25b REGISTRAR'S SIGNATURE <b>[Signature]</b>

25a RECORDED BY REGISTRAR  
DEC 30 1966  
DATE



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

17184

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Frederick County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RFD#2 Taneytown</i>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>RFD#1 Taneytown, Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Clayton Sylvester Staub</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clayton Sylvester Staub</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>25</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 3, 1904</i>
9a. AGE (In years last birthday) <i>62</i> yrs		9b. F UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Frederick Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Roy C. Staub</i>		14. MOTHER'S MAIDEN NAME <i>Mary S. Fogle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of serv. etc.)		16. SOCIAL SECURITY NO <i>216-10-0354</i>	
17. INFORMANT <i>Robert C. Staub</i> Address <i>R. D. 3, Emmitsburg, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO (b) <i>Arteriosclerotic C.V.D.</i> DUE TO (c) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i> <i>7</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Bernard D. Thomas</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/28/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lutheran Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Taneytown, Carroll Co., Md.</i>
24. FUNERAL DIRECTOR <i>Richard A. Little</i> ADDRESS <i>Littlestown, Pa.</i>		25a. REC'D BY REGISTRAR <i>DEC 27 1966</i> DATE	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

22. DATE SIGNED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p><b>17185</b></p> </div> <div> <p><b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b></p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>17177</b></p> </div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <span style="float: right;">MARYLAND</span>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11 West 'C' Street</b>					d. STREET ADDRESS <b>same</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>CATHERINE</b> <sup>First</sup> <b>REBECCA</b> <sup>Middle</sup> <b>STINE</b> <sup>Last</sup>					<b>4. DATE OF DEATH</b> <b>12</b> <sup>Month</sup> <b>9</b> <sup>Day</sup> <b>66</b> <sup>Year</sup>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDDED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4/19/1883</b>		<b>9. AGE</b> (In years last birthday) <b>83</b> <sup>yrs.</sup> <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months <b>8</b> Days <b>3</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>GEORGE WATTS</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY E. KELLER</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>Mrs. Mary Edna LaPole Baltimore Md.</b> <sup>Address</sup>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke - Atherosclerosis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>10 yrs</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>DR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>6/12/1929</b> <b>to</b> <b>12/9/1966</b> <b>that (I) (we) last saw the deceased alive on</b> <b>12/9/1966</b> <b>and that death occurred at</b> <b>3:22 M.</b> <b>from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>J.G.F. Smith</i>								<b>22b. DATE SIGNED</b> <b>12/16/66</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>J.G.F. Smith, M.D.</b>				<b>22d. ADDRESS</b> <b>Brunswick Maryland</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/11/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lutheran Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) <b>Middletown</b> <b>(State)</b> <b>Maryland</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Ecce Funeral Home</b> <sup>ADDRESS</sup>				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 13 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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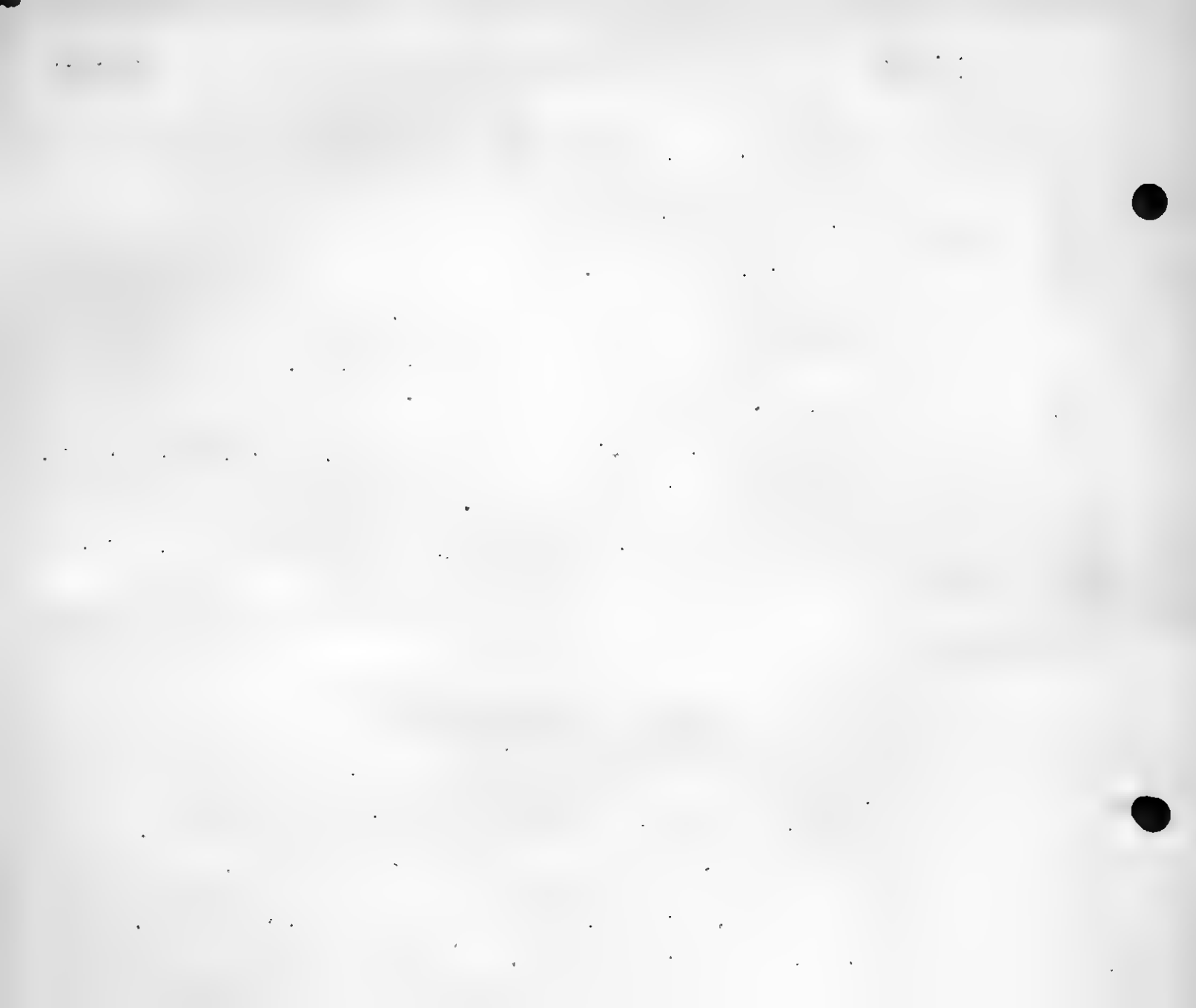
(M)

94

MEDICAL CERTIFICATION

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17186						17178					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Frederick			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 19 yrs			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue County Home		
a. STATE Maryland			b. COUNTY Frederick			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia			d. STREET ADDRESS 19.1		
3. NAME OF DECEASED (Type or print) First: Harry Middle: M. Last: Thompson						4. DATE OF DEATH Month: Dec. Day: 21 Year: 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1888		9. AGE (in years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Monrovia, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Thompson						14. MOTHER'S MAIDEN NAME Frances Cook					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-14-6273T		17. INFORMANT Mrs Nannie Browning, Monrovia, Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 3 days 4 years.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> , 19 <i>63</i> , to <i>Dec 21</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Dec 21</i> , 19 <i>66</i> , and that death occurred at <i>1:30</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>LeRoy T Davis</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/21/66</i>			
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis						22d. ADDRESS Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1966		23c. NAME OF CEMETERY OR CREMATORY Providence Meth.		23d. LOCATION (City, town or county) (State) Kemptown, Md.					
24. FUNERAL DIRECTOR Olin L. Nolesworth, Damascus, Md.						25a. REC'D BY REGISTRAR DEC 28 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



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42-2

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
17187						17179					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			Frederick			a. STATE			Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Frederick			b. COUNTY			Frederick		
c. LENGTH OF STAY IN 1b			Maryland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Myersville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
Frederick Memorial Hospital						RD 2			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. IS RESIDENCE ON A FARM?		
First Middle Last						Month Day Year			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Nellie Grace Toms						Dec. 5 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8-10-1884		82 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife				Own Home		Maryland			USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
James Linton						Amanda Lewis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
No				None		Roy Green			Lantz. Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis											
4201 DUE TO (b) atherosclerotic Heart Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Nov 19, 1966, to Dec 5, 1966, that (I) (we) last saw the deceased alive on Dec 5, 1966, and that death occurred at 7:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE											
Henry V. Chase											
22b. DATE SIGNED											
5 Dec '66											
22c. PHYSICIAN'S NAME (Type)											
Henry V. Chase											
22d. ADDRESS											
804 Toll House Ave Frederick, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial				12-8-66		Mt. Bethel Cemetery		Mr. Foxville Fred. Co			
24. FUNERAL DIRECTOR											
Raymond E. Croager											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
DATE DEC 12 1966											



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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17188

CERTIFICATE OF DEATH

17180

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg,</b>			c. LENGTH OF STAY IN 1b <b>30 70 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>R.D.# 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Janson</b> Last <b>Wasilifsky</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24, 1906</b>		9. AGE (In years) <b>60</b> yrs	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James H. Schmidt</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Janson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-6134</b>		17. INFORMANT Address <b>Adolph Wasilifsky, Emmitsburg, Md. R.D.#1</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>0</b> (this hospital) attended the deceased from <b>April 14, 1961</b> , to <b>Nov 28, 1966</b> that <b>0</b> (we) last saw the deceased alive on <b>Nov 28, 1966</b> , and that death occurred at <b>6 A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>George P. Morningstar</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Dec. 3, 66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. George Morningstar</b>				22d. ADDRESS <b>Emmitsburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony's Shrine</b>		23d. LOCATION (City or Town) (County) (State) <b>Emmitsburg, Frederick Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Clarence E. Wilson</b>				25a. REC'D BY REGISTRAR <b>Clarence E. Wilson</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
ADDRESS <b>Emmitsburg, Md.</b>				DATE <b>DEC 5 1966</b>			

36



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17189

## CERTIFICATE OF DEATH

17181

1 PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> ✓	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>11</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Nursing Center</b>		d. STREET ADDRESS <b>806 Park Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>Mrs. Selma Watkins</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1893</b>
9. AGE (in years last birthday) <b>73 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eldridge Mullinix</b>		14. MOTHER'S MAIDEN NAME <b>Rozena Merson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-28-5668</b>	
17. INFORMANT <b>Rudy E. Watkins, Item 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I. DEATH WAS CAUSED BY <b>420.0</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Severe Arteriosclerotic Heart Disease</b> DUE TO (c) <b>6 mo</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1966</b> , to <b>Dec. 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 26, 1966</b> , and that death occurred at <b>7:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. A. Pearre, Sr.</b> M.D.		22b. DATE SIGNED <b>12/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. A. Pearre, Sr.</b>		22d. ADDRESS <b>Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 29, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>		23d. LOCATION (City or Town) (County) (State) <b>Claggettville, Md.</b>	
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

17190

17182

<b>1. PLACE OF DEATH</b> a. COUNTY <u>FREDERICK</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO</u> c. LENGTH OF STAY IN <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RURAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO</u> d. STREET ADDRESS <u>RURAL</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>HARVEY HARRISON WERKING</u> First Middle Last <b>4. DATE OF DEATH</b> <u>DEC 3</u> 19 <u>66</u> Month Day Year		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>SEPT. 12-1888</u> <b>9. AGE</b> (In years last birthday) <u>78</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER-PRODUCE DEALER - RETIRED</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MARYLAND</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>JAMES C. WERKING</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>AMANDA STOVER</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>217-32-5943</u> <b>17. INFORMANT</b> <u>CATHERINE T. WERKING</u> Address <u>WOODSBORO MD</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LYMPHO SARCOMA, LEFT EPITROCHLEAR LYMPH NODE</u> DUE TO <u>WITH METASTASES TO SPINE, CERVICAL, PREAURICULAR</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. } DUE TO <u>AXILLARY, INGUINAL &amp; MésentERIC NODES</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE SECONDARY PANCYTOPENIA RESULTANT FROM TUMOR &amp; URACIL</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>3 YEARS</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year <u>12/12/66</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>WALKERSVILLE MD</u> <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>SEPT 1964</u> <b>to</b> <u>12/13/66</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12/12/66</u> <b>and that death occurred at</b> <u>2:30 PM</u> <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>James E. Stoner, Jr.</u> <b>22b. DATE SIGNED</b> <u>12/3/66</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>JAMES E. STONER, JR.</u> <b>22d. ADDRESS</b> <u>WALKERSVILLE MD</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>12-6-66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. HOPE CEM.</u> <b>23d. LOCATION (City, town or county)</b> <u>WOODSBORO MD</u> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Powell &amp; Hartzle</u> <b>25a. REC'D BY REGISTRAR</b> <u>DEC 7 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

17191

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17183

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Rt. # 340</b>		c. LENGTH OF STAY IN 1b <b>340</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Frederick</b>		d. STREET ADDRESS <b>Route # 4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>POA Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>LEE ALBERT WHIPP</b>				<b>4. DATE OF DEATH</b> December 18, 1966			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 6, 1942</b>	
<b>9. AGE</b> (In years last birthday) <b>24</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days		<b>11. IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Frederick County, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Harry R. Whipp</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Naomi Wirtz</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-38-0377</b>		<b>17. INFORMANT</b> Address <b>Mrs. Gloria B. Whipp Route # 4 Frederick, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 825.4 DUE TO (b) <b>Subdural &amp; Subarachnoid Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Fractured Skull</b>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>6:30 p.m. 12-18-66</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		<b>20f. (City or town) (County) (State)</b> <b>Frederick - Frederick - Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>Dr. B. O. Thomas, Sr.</b> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME</b> (Type) <b>DR. B. O. THOMAS, SR. M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
				<b>DATE SIGNED</b> <b>12-18-66</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12-21-1966</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Reformed Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Frederick Co. Maryland</b>	
<b>23. FUNERAL DIRECTOR</b> <b>Robert E. Dailey &amp; Son</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			
<b>24a. REC'D BY REGISTRAR</b> <b>DATE 12-23-1966</b>							



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

17192

17184

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN b. <u>Month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montevue Infirmary</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u> Loudoun </u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Lovettsville </u> d. STREET ADDRESS <u> Route 1 </u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>ANNA</u> <u>BELLE</u> <u>WILLIAMS</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>December 30,</u> <u>19 66</u> Month Day Year	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 2, 1879</u> <b>9. AGE</b> (In years last birthday) <u>87</u> yrs <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Henry Stout</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Bates</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>219 54 2330</u> <b>17. INFORMANT</b> <u>Montevue Infirmary Records</u> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic gastritis</u> (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 1962</u> <b>to</b> <u>Dec 30, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 30, 1966</u> , <b>and that death occurred at</b> <u>5 PM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Leroy T. Davis</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Leroy T. Davis, M. D.</u>		<b>22b. DATE SIGNED</b> <u>Dec. 31, 1966</u> <b>22d. ADDRESS</b> <u>228 N. Market Street, Frederick, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Jan. 3, 1967</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Union Cemetery,</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Lovettsville, Va.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank R. Smith, Jr.</u> <u>M. R. Etchison &amp; Son, Frederick, Maryland</u> <b>25a. REC'D BY REGISTRAR</b> <u>JAN 3 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>John L. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

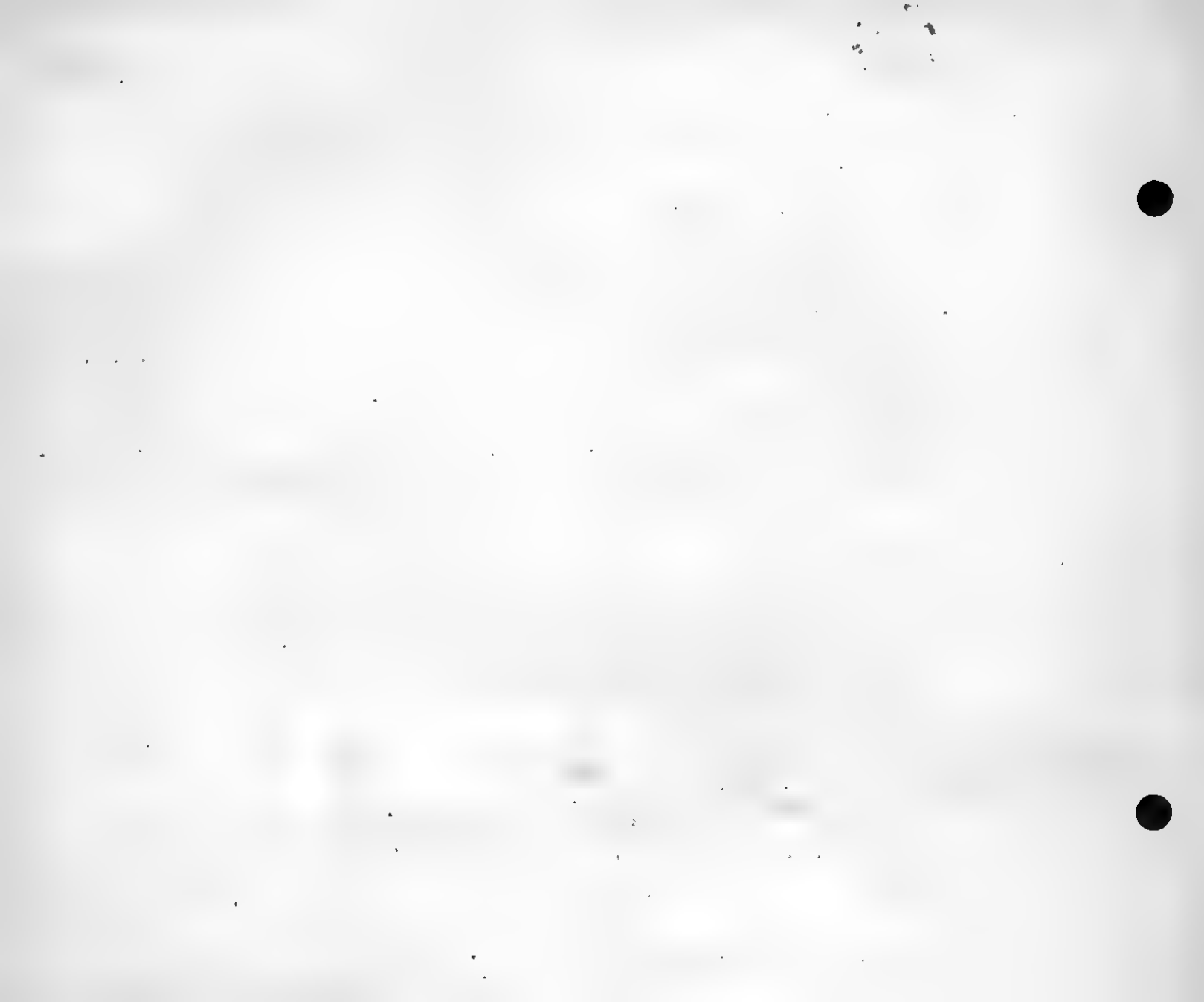


1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17193  
17185  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 105 West 'C' Street		d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST HENRY NELSON YATES		4. DATE OF DEATH Month 12 Day 2 Year 1966	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired engineer		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	9. AGE (In years last birthday) 74
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) no		16. SOCIAL SECURITY NO. 705-10-2551	
17. INFORMANT Robert O. Decker		Address Brunswick Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 18 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/19/65 to 12/1/66 that (I) (we) last saw the deceased alive on 12/1/66 and that death occurred at 7 AM, from the causes and on the date stated above.			
22a. SIGNATURE J.G.F. SMITH, M.D.		22b. DATE SIGNED 12/13/66	
22c. PHYSICIAN'S NAME (Type) J.G.F. SMITH, M.D.		22d. ADDRESS Brunswick Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 12/4/66	
23c. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery		23d. LOCATION (City, town or county) (State) Middletown Virginia	
24. FUNERAL DIRECTOR Fute Funeral Home		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS Brunswick Md.		DATE DEC 5 1966	





## CERTIFICATE OF DEATH

17194

17186

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Own Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Daisy Zentz</b>		4. DATE OF DEATH Month Day Year <b>Dec. 21 1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1872</b>
9. AGE (In years last birthday) yrs. <b>94</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>William Smith</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Harbaugh</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Albert Zentz Thurmont, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO (b) <b>Virus infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Dec 14, 1966</b> , to <b>Dec 21, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec 20, 1966</b> , and that death occurred at <b>10 A.M.</b> from causes and on the date stated above.	
22a. SIGNATURE <b>James K. Gray</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		22d. ADDRESS <b>Thurmont, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-24-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Thurmont Fred. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S ADDRESS <b>Thurmont, Md.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17186

17186

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]*

*[Faint vertical text on the right margin, possibly bleed-through.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 8 Film G383 12/14/66 mh

17195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17187

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>313 1/2 West South Street</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>312 1/2 West South Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM A. ZIMMERMAN, Jr.</b>				4. DATE OF DEATH <b>December 5 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1912 March 12, 1915</b>	9. AGE (In years last birthday) <b>54</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Arlans Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William A. Zimmerman, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. W. # 2 214 09 0255</b>		17. INFORMANT <b>Miss W. Patrick St. William A. Zimmerman, 3rd. Frederick, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. O. Thomas</b>		EXAMINER'S NAME (Type) <b>B. O. Thomas, Sr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>12-5-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 8, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	23d. LOCATION (City or Town) <b>Fort Myers, Va.</b> (County) _____ (State) _____				
24. FUNERAL DIRECTOR <b>Monale M. M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

1312

1312